

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05193

Reg. D. N. No.

WHO IS A PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

WHO IS A FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 HOUR ATTENDING PHYSICIAN: The law requires that he be retained by the hospital or attending physician.

WHO IS A PHYSICIAN? The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

WHO IS A FUNERAL DIRECTOR? After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/S7

1. PLACE OF DEATH o. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 40 yrs		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital				d. STREET ADDRESS 518 Virginia Ave.				
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harry William Abbott		First	Middle	Last	4. DATE OF DEATH May 13 1960	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 23, 1893	9. AGE (In years lost birthday) 66	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Newark, Ohio		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Abbott				14. MOTHER'S MAIDEN NAME Nancy Burton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 705-07-9735		17. INFORMANT Mrs. Harry W. Abbott, Cumberland, Md.		
Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular failure								
DUE TO 420								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary occlusion								
DUE TO								
(c) Coronary arteriosclerosis; myocardial fibrosis								
INTERVAL BETWEEN ONSET AND DEATH sudden								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month November	Day 19	Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 50 Pershing St.	20f. (City or town) Cumberland	(County) Maryland
(State) MD								
21. I certify that I attended the deceased from November 19, 1941 , to May 13, 1960 , that I last saw the deceased alive on May 20, 1960 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) 50 Pershing St.								
DATE SIGNED 5/16/60								
ACTUAL SIGNATURE Samuel Jacobson								
PHYSICIAN'S NAME (Type) Dr. Samuel M. Jacobson, MD								
Cumberland, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-1960		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		
(State) MD								
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS				
				24a. REC'D BY REGISTRAR DATE MAY 19 '60				
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

1. **CHRONIC PAIN** – PAIN LASTING 12 WEEKS OR LONGER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

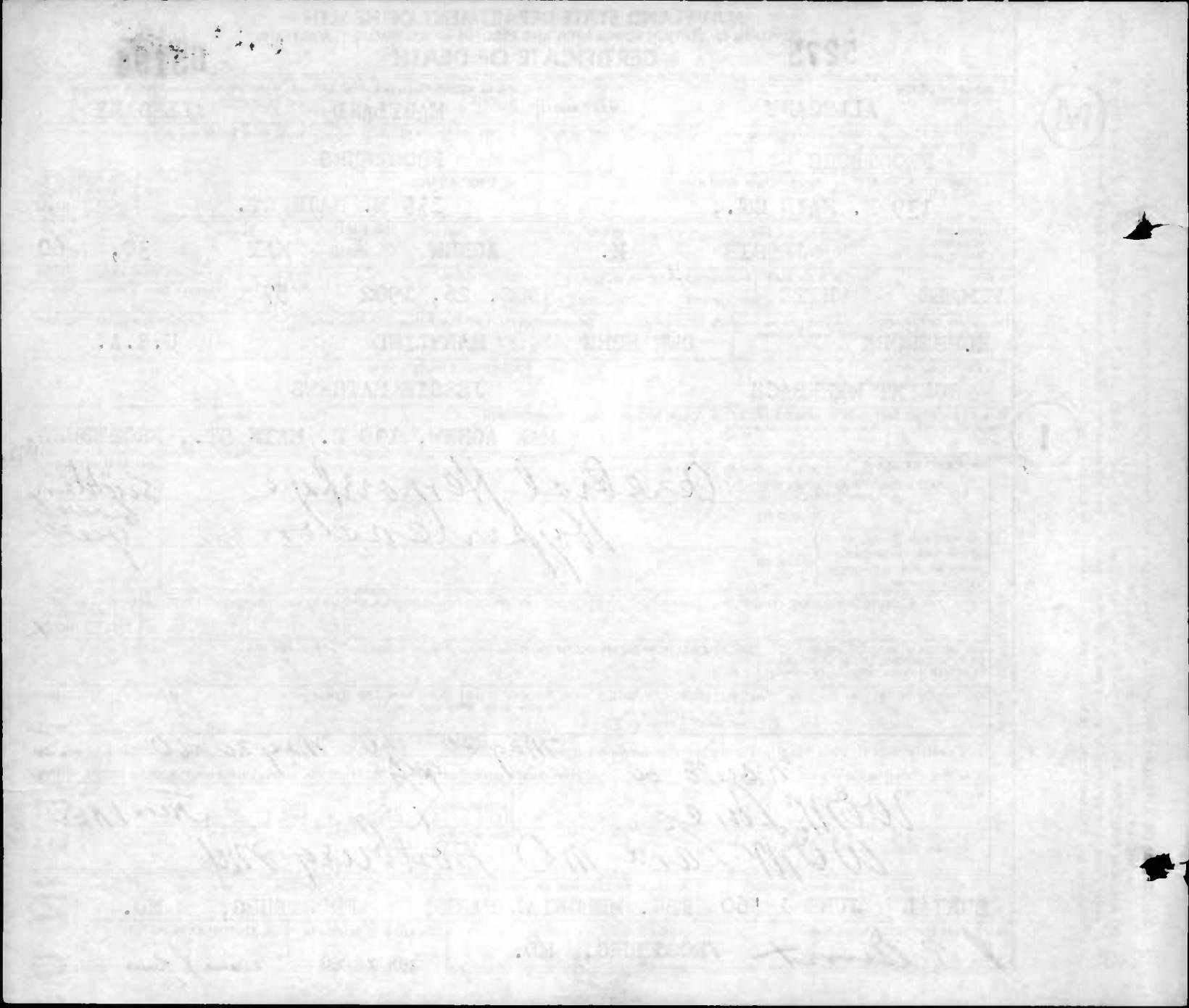
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5275

05194

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 22		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 E. MAIN ST.,		e. STREET ADDRESS 139 E. MAIN ST.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First JESSIE	Middle M.	Last AGNEW	
4. DATE OF DEATH	MAY	Month	Day 30, Year 1960	
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 26, 1902	
9. AGE (In years last birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	11. KIND OF BUSINESS OR INDUSTRY OWN HOME	12. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT MERRBACH	14. MOTHER'S MAIDEN NAME JESSIE MATHEWS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT MAX AGNEW, 139 E. MAIN ST., FROSTBURG,	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden, several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 30, 1960 , to May 30, 1960 , that (I) (we) last saw the deceased alive on May 26, 1960 , and that death occurred 9:00 P.M. from the causes and on the date stated above.				
22a. SIGNATURE WOMC Lane		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED June 1, 1960
22c. PHYSICIAN'S NAME (Type) WOMC Lane MD		22d. ADDRESS Frostburg MD		
23a. BURIAL, CREMATION, BURIAL (Specify) BURIAL	23b. DATE THEREOF JUNE 1 '60	23c. NAME OF CEMETERY OR CREMATORIAL FBG. MEMORIAL PARK	23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Deurst		ADDRESS FROSTBURG, MD.	25a. REC'D BY REGISTRAR DATE JUN 2 '60	25b. REGISTRAR'S SIGNATURE John S. K.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5203 CERTIFICATE OF DEATH

05195
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/21/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Obie	Middle Wilson	Last Arnold
4. DATE OF DEATH	Month May	Day 6,	Year 19 60
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/1872
9. AGE (In years last birthday) yrs. 87	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - La Vale Glass Worker	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME Luther Arnold		14. MOTHER'S MAIDEN NAME Matilda Queen	
IS. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Chronic Myocardial Degeneration INTERVAL BETWEEN ONSET AND DEATH ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis, ? (c) Senile Deterioration ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Thrombo-augictic Obliterans 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/21/60 , 19, to 5/6/60 , 19, that I last saw the deceased alive on 3/6/60 , 19, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/7/60			
ACTUAL SIGNATURE <i>James E. McLean</i>		M.D.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/60	
22c. NAME OF CEMETERY OR CREMATORIAL Davis		22d. LOCATION (City, town, or county) (State) W. Va. Davis	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle Davis, W. Va.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE MAY 10 '60	
		24b. REGISTRAR'S SIGNATURE C. S. Evans	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5276

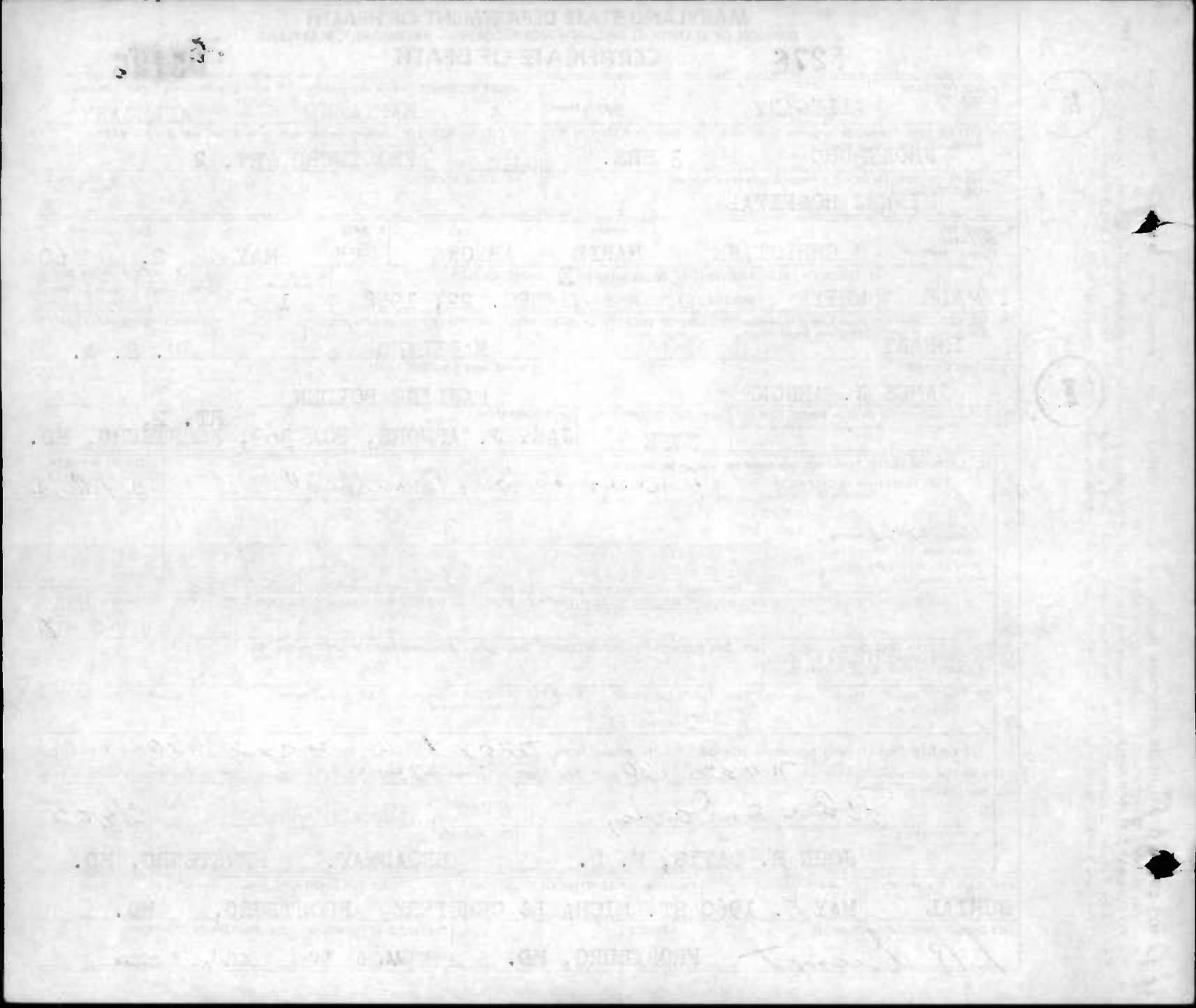
CERTIFICATE OF DEATH

05196

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 HRS.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MINERS HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First CHRISTINE	Middle MARIE	Last ARNONE	
4. DATE OF DEATH	Month MAY		Day 2	Year 1960
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DEC. 22, 1958	9. AGE (In years last birthday) 1 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME JAMES J. ARNONE		14. MOTHER'S MAIDEN NAME PAULINE BOLDEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT JAS. J. ARNONE, BOX 369, FROSTBURG, MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address RT. 2,		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO				
(c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May 1 1960 to May 2 1960 that (I) (we) last saw the deceased alive on May 2 1960 and that death occurred at 2 PM , from the causes and on the date stated above.				
22o. SIGNATURE <i>John B. Davis</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/4/60	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS BROADWAY, FROSTBURG, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 5, 1960	23c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAELS CEMETERY	23d. LOCATION (City, town, or county) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. P. Luerst</i>		ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE MAY 6 '60
				25b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

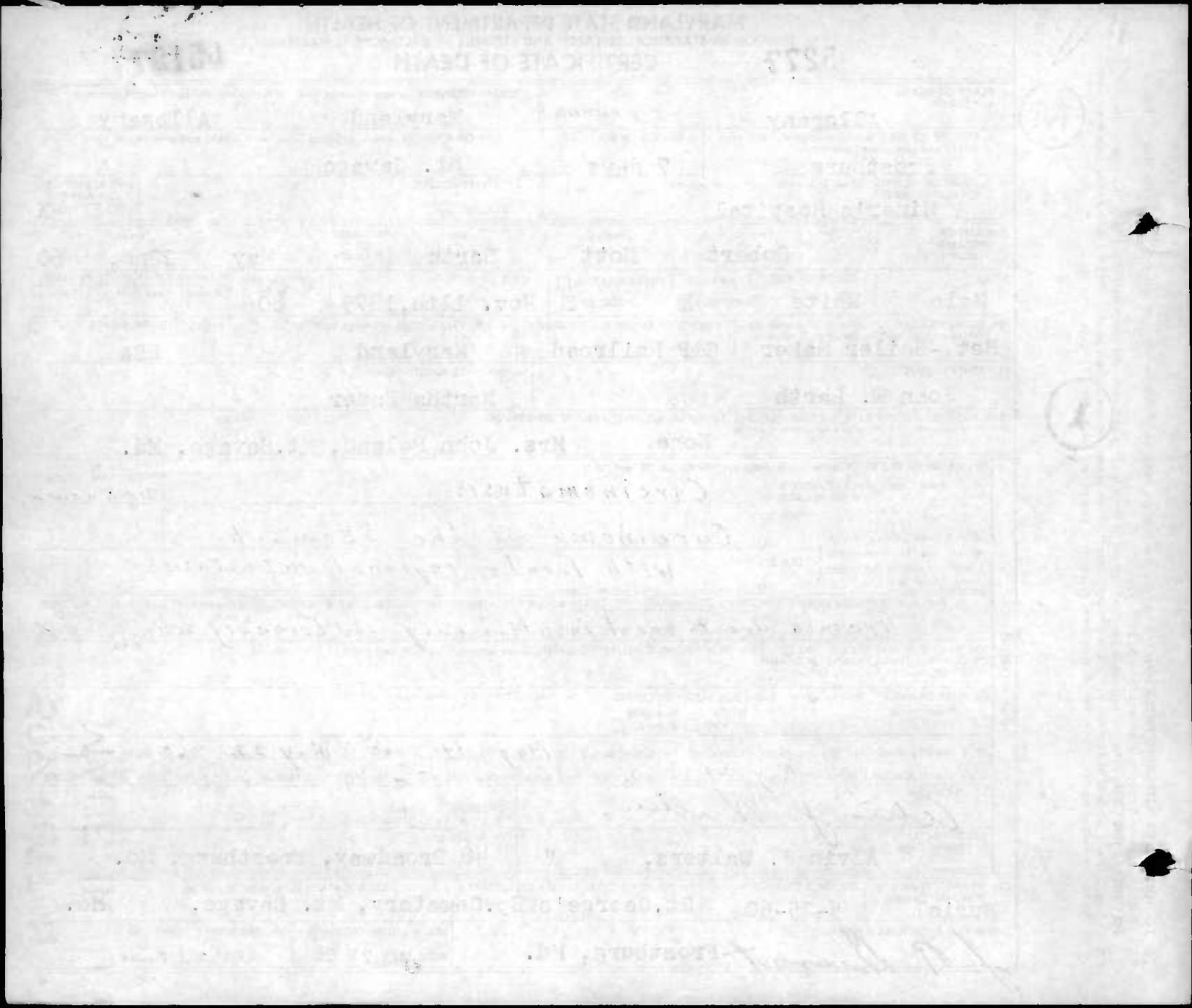
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		85197		
5277														
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage			d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital														
3. NAME OF DECEASED (Type or print)		First Robert	Middle Nott	Last Barth	4. DATE OF DEATH		Month May	Day 22nd, 1960	Year					
5. SEX		6. COLOR OR RACE Male White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 11th, 1879	9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80		IF UNDER 24 HRS. Days 0 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Boiler Maker			10b. KIND OF BUSINESS OR INDUSTRY C&P Railroad			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John W. Barth					14. MOTHER'S MAIDEN NAME Martha Bauer									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. None			17. INFORMANT Mrs. John Poland, Mt. Savage, Md.			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					Garcinomatosis					INTERVAL BETWEEN ONSET AND DEATH Unknown.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia due to renal insufficiency and Coronary sclerosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from May 14, 1960 , to May 22, 1960 , that (II) (we) last saw the deceased alive on May 21, 1960 , and that death occurred at 6:22 AM , from the causes and on the date stated above.														
22a. SIGNATURE Alvin J. Walters.					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 25/5/60						
22c. PHYSICIAN'S NAME (Type) Alvin J. Walters,					22d. ADDRESS 48 Broadway, Frostburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-25-60		23c. NAME OF CEMETERY OR CREMATORIAL St. George's Ep. Cemetery, Mt. Savage,			23d. LOCATION (City, town, or county) Md.			(State)				
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Duest					ADDRESS Frostburg, Md.			25a. REC'D BY REGISTRAR MAY 25 '60		25b. REGISTRAR'S SIGNATURE C. J. May S. Kraus				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5204 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05198

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ohio</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Circleville</i>		c. LENGTH OF STAY IN 1b		b. COUNTY <i>Cuyahoga</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berea Ohio</i>		
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Algonquin Hotel</i>				d. STREET ADDRESS <i>6041 Engle Road.</i>				
3. NAME OF DECEASED (Type or print)		First <i>Joseph</i>	Middle <i>S.</i>	Last <i>Beamer</i>	4. DATE OF DEATH <i>May 19</i>	Month <i>May</i>	Day <i>19</i>	Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Jan 4, 1899</i>	9. AGE (in years last birthday) <i>61</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>
8. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BMI Recording Co West Bridgewater</i>		11. BIRTHPLACE (State or foreign country) <i>West Bridgewater U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Joseph C. Beamer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Duncan</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs Elma M. Nett</i>		Address <i>New York</i>		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 490.1 (b) CORONARY SCLEROSIS DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH SUDDEN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Pittsburgh Pa</i>	(County) <i>Pittsburgh Pa</i>	(State) <i>Pittsburgh Pa</i>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
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MEDICAL CERTIFICATION								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> DATE SIGNED								
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <i>BENEDICT SKITARELIC, M.D.</i> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 19 1960								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>5/20/60</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Bainbridge Cemetery</i>		22d. LOCATION (City, town, or county) <i>Pittsburgh Pa</i> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. Camb. Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE		
				DATE MAY 23 '60				

TO DEFENDANT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Digitized by srujanika@gmail.com

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be rebained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

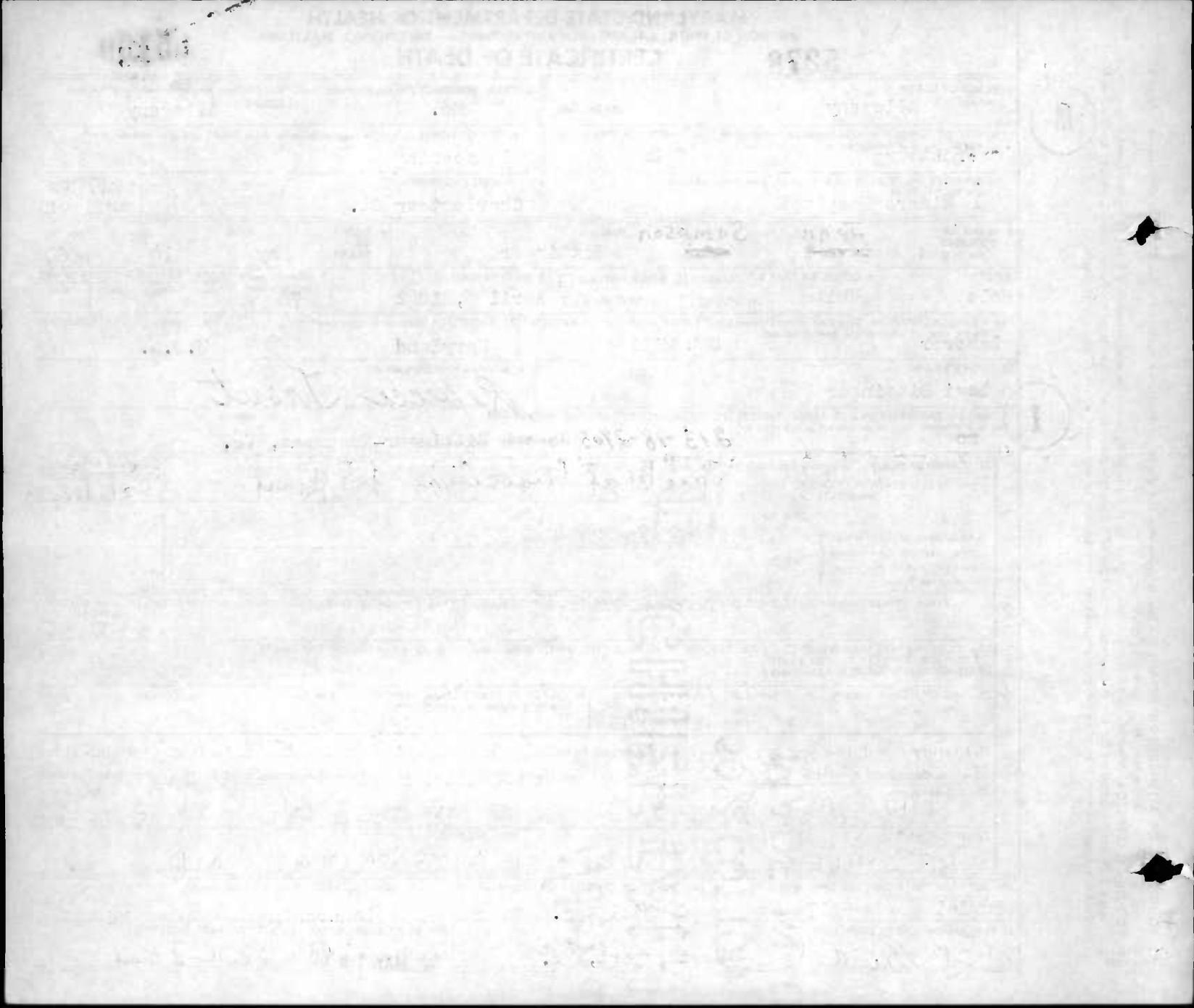
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5278

CERTIFICATE OF DEATH

65199

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5 Ds		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Charlestown St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	John	First	Sampson	Middle	Last	4. DATE OF DEATH	Month May	Day 14	Year 19 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH April 6, 1882	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Levi Bittinger					14. MOTHER'S MAIDEN NAME Rebecca Trout								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-18-2905		17. INFORMANT Joseph Bittinger-Manassas, Va.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral vascular accident INTERVAL BETWEEN ONSET AND DEATH 36 hours Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerosis (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 9.22 1960 to 5.14 1960 that (I) (we) last saw the deceased alive on 5.14 1960, and that death occurred at 2 P.M. from the causes and on the date stated above.													
22a. SIGNATURE J. Miles, Jr., M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5.16.60						
22c. PHYSICIAN'S NAME (Type) J. R. MILES, JR., M.D.				22d. ADDRESS Lonaconing MD									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17		23c. NAME OF CEMETERY OR CREMATORIAL Oakhill Cem.		23d. LOCATION (City, town, or county) (State) Lonaconing Md							
24. FUNERAL DIRECTOR'S SIGNATURE E. Boral		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							
				DATE MAY 18 '60									



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

DOCTOR, HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 26 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
3. NAME OF DECEASED (Type or print)		First RAYMOND	Middle LEROY	Last BORST	4. DATE OF DEATH MAY 11, 1960
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 17, 1902	9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ft. Conductor		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) NEW YORK, Delhi	
13. FATHER'S NAME JUDSON BORST		14. MOTHER'S MAIDEN NAME NANCY MC CUNE		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		Carcinoma of Lung (2)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO		(b) DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Hour a.m. — 19 p.m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Alley Med	
21. I certify that (I) (this hospital) attended the deceased from 3/7/58 19 to 5/11/60 19, that (I) (we) last saw the deceased alive on 6/10/60, and that death occurred at 7:40 AM, the causes and on the date stated above.					
22a. SIGNATURE O. R. Williams		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/14/60	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 13, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 16 '60	
				25b. REGISTRAR'S SIGNATURE Arthur J. Hafer	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5291

CERTIFICATE OF DEATH

15201

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #1 FLINTSTONE		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RT. #1 FLINTSTONE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		d. STREET ADDRESS / RT. #1 FLINTSTONE	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GEORGE	Middle E.	Last BROCKEY
4. DATE OF DEATH	MAY 29		Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1890
9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor	10b. KIND OF BUSINESS OR INDUSTRY P. E. Street Cars	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHRISTOPHER F. BROCKEY	14. MOTHER'S MAIDEN NAME MARGARET HUMBERTSON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT PTS. CHART	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490.0 DUE TO arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 1 week			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Generalized arteriosclerosis (c) 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5-24 1960 to 5-29 1960 , that (I) (we) last saw the deceased alive on 5-28 1960 and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE L. Brings		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS		22d. ADDRESS 576 Green St. Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 1, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Chaneyville Methodist	23d. LOCATION (City, town, or county) Chaneyville (State) Pa.
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, 230 Baltimore Ave. Cumberland	ADDRESS DATE JUN 3 '60	25a. REC'D BY REGISTRAR Arthur S. Trahan	25b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5289

05202

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Carl	Middle Edward	Last Burkhart	4. DATE OF DEATH Month May	Day 28th, 1960	Year
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 18th, 1914	9. AGE (In years last birthday) 46Yrs.	10. IF UNDER 1 YEAR Months 4	11. IF UNDER 24 HRS. Days 6	12. Hours 0	13. Min. 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shovel Operator	10b. KIND OF BUSINESS OR INDUSTRY Co. Mt. Savage Coal	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Henry Burkhart	14. MOTHER'S MAIDEN NAME Carrie Finzel
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 215-10-1272	17. INFORMANT Richard Burkhart, Mt. Savage, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH approx 15 min.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a), 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
acute coronary thrombosis	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

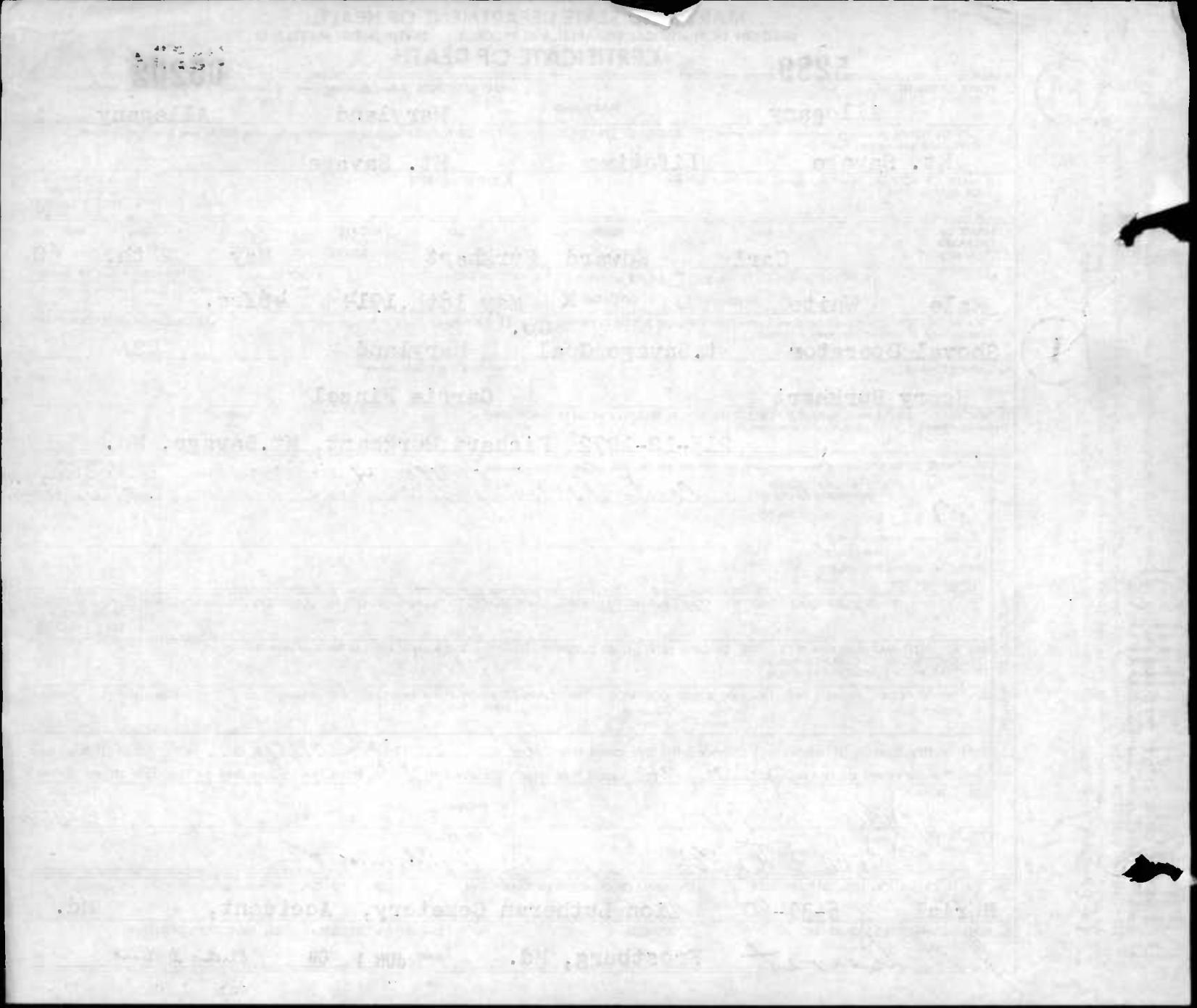
21. I certify that (I) (this hospital) attended the deceased from July 1957 to 5/28/60 , 19_____, that (I) (we) last saw the deceased alive on April 19 1960 , and that death occurred at 320A , from the causes and on the date stated above.
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22a. SIGNATURE John A. Tapper	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATED SIGNED 5-31-60
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22c. PHYSICIAN'S NAME (Type) John A. Tapper	22d. ADDRESS Hyndman St
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-31-60	23c. NAME OF CEMETERY OR CREMATORIAL Zion Lutheran Cemetery, Accident	23d. LOCATION (City, town, or county) (State) Md.
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24. FUNERAL DIRECTOR'S SIGNATURE J.P. Durst	ADDRESS Frostburg, Md.	25a. REC'D BY REGISTRAR DATE JUN 1 '60	25b. REGISTRAR'S SIGNATURE Charles L. Krause
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEFECTIVE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. Return to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File Pages 1 and 2 with the registrar, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS Route 5,		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE A. CAPEL		First	Middle
		Last	4. DATE OF DEATH Month May
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Sept. 15, 1941
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		11b. KIND OF BUSINESS OR INDUSTRY Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George A. Capel, Sr.	
14. MOTHER'S MAIDEN NAME Elsie Dawson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220 38 0027		17. INFORMANT Address Mr. George Capel, Route 5, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 40 Minutes 816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Skull Fracture 40 Minutes (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident MV vs MV	
20c. TIME OF INJURY Month, Day, Year Hour 3:00 p.m. May 8 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pt. #220 Rt. #5 Cumberland, Allegany, Maryland 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED May 8, 1960	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR MAY 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATEMENT OF DEBT		CREDITORS & AMOUNTS	
1.	2.	3.	4.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
520 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. #45204

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES E. CAPEL		Last E	4. DATE OF DEATH Month MAY Day 8 Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1943
9. AGE (in years last birthday) 17 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Capel, Sr.		14. MOTHER'S MAIDEN NAME Elsie Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT		Address George Capel, Route 5, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Skull Fracture DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 30 Minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year Hour— 3:00 p.m. May 8 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 220 Rt. #5 Cumberland, Allegany, Maryland
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED May 8, 1960	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park
22d. LOCATION (City, town, or county) Frostburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR MAY 11 '60
			24b. REGISTRAR'S SIGNATURE Arthur J. Turner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

EDUCATIONAL OUTCOMES OF CERTIFICATE OF LEARNERSHIP

31. 1900-1910. B144-10. THE MASTERS OF THE 20TH CENTURY.
THEATRE AND FILM. 2 VOLS. HARDBOUND. 24X30CM. 1000 PAGES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5208

CERTIFICATE OF DEATH

Reg. # 85205

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 761 Fayette St.,			d. STREET ADDRESS 600 Washington St.,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Hattie Middle Cecelia Last Cavey	4. DATE OF DEATH	Month May	Day 23, Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years (not birthday) yrs.)	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Miles			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Edward C. Cavey	Address Cumberland, Md. 600 Washington St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) <i>Decades of age</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>years</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>1</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Cumberland Alleg. Md.</i>	20f. (City or town) <i>Cumberland Alleg. Md.</i>	(County) (State)
21. I certify that I attended the deceased from <i>5/17/60</i> , 19_____, to <i>5/23/60</i> , 19_____, that I last saw the deceased alive on <i>5/21/60</i> , 19_____, and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Richard J. Williams, M.D.</i>				ADDRESS (Street, city or town, state) <i>122 So. Centre St.,</i>	DATE SIGNED <i>5/23/60</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/60	22c. NAME OF CEMETERY OR CREMATORIUM Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George			ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAY 25 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traub</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Hours after death. Page 4 may be signed by the hospital or attending physician.

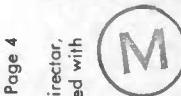
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.

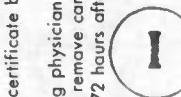
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5209

CERTIFICATE OF DEATH

05206
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 6/7/55	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
f. STREET ADDRESS 1		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ann	Middle Ricker	Last Coleman
4. DATE OF DEATH	Month May	Day 19,	Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/1901
9. AGE (In years last birthday) 59 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Frank Ricker		
14. MOTHER'S MAIDEN NAME Mary Mills	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 59 (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		INFORMANT P.O. Box 599 Address Cumberland, Md.	
ALLEGANY COUNTY INFIRMARY RECORDS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis , DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause last. 59			
(b) Cerebral arteriosclerosis , DUE TO Epilepsy , (c) Chronic nephritis , DUE TO INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/7/55 , 19, to 5/19/60 , 19, that I last saw the deceased alive on 6/18/60 , 19, and that death occurred at 9:05A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/19/60	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/1960	
22c. NAME OF CEMETERY OR CREMATORIUM St. Marys Cemetery		22d. LOCATION (City, town, or county) Lonaconing, MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONA CONING? MD.	
24a. REC'D BY REGISTRAR Armen S. Kraus		24b. REGISTRAR'S SIGNATURE Armen S. Kraus	

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BRITISH MEDICAL JOURNAL LONDON: 1891. VOL. 1. PART 1. APRIL 1.

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Revised edition

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

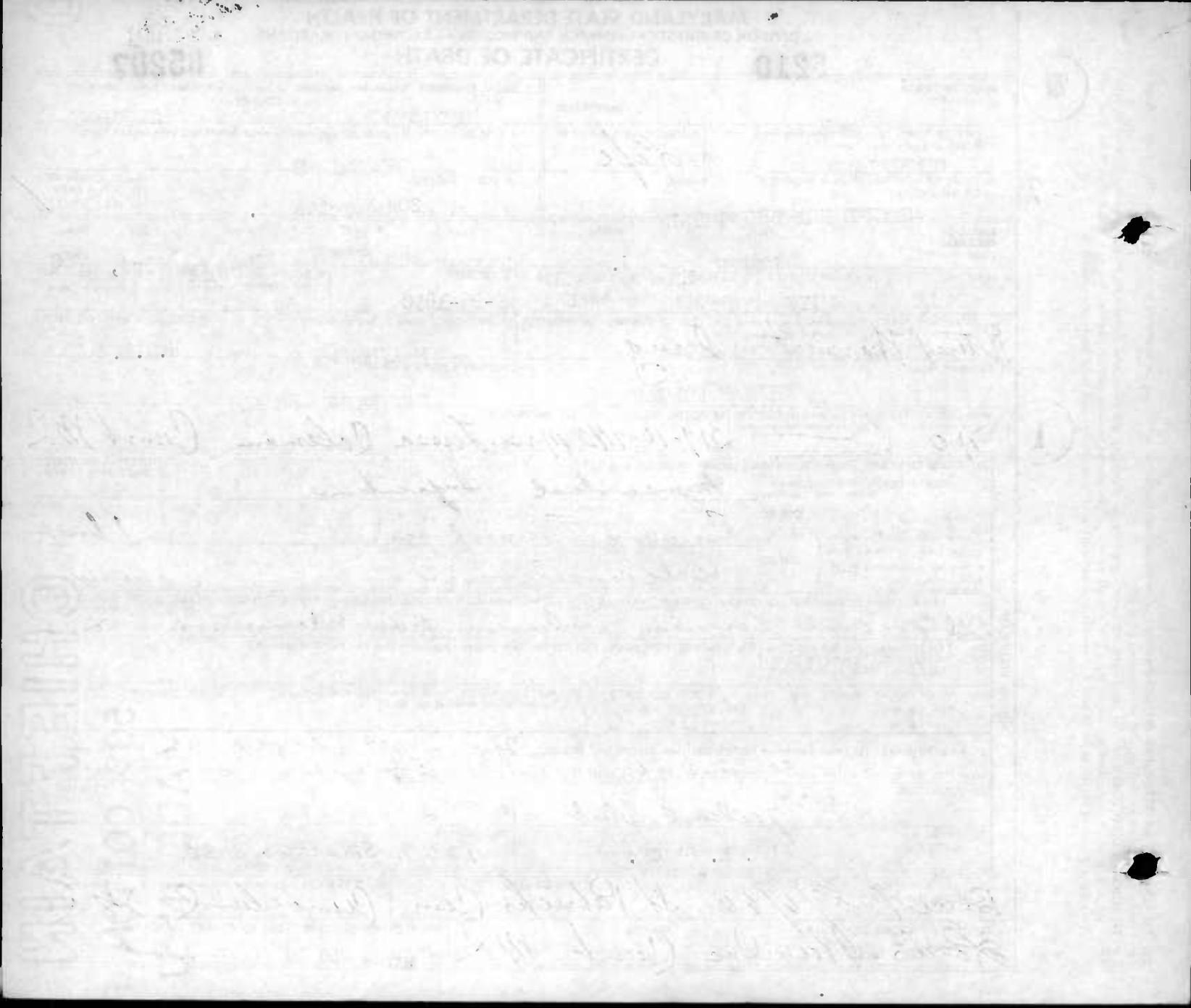
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5210

CERTIFICATE OF DEATH

05207

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle J.	Last COLEMAN
4. DATE OF DEATH			Month MAY
5. SEX	6. COLOR OR RACE MALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WHITE	8. DATE OF BIRTH 9-26-1890
9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pharmacist	11. KIND OF BUSINESS OR INDUSTRY Drug	12. CITIZEN OF WHAT COUNTRY? MARYLAND
13. FATHER'S NAME WILLIAM COLEMAN	14. MOTHER'S MAIDEN NAME CATHERINE FRIELE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. 219-10-493	17. INFORMANT Mrs. Leresa Coleman	Address Cumb. Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			INTERVAL BETWEEN ONSET AND DEATH
4001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis			1 hour
(c) Arteriosclerosis			until
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) De Cerebral Vascular occlusion from Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> 19	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 19 57 to 30 April 1960 , that (I) (we) last saw the deceased alive on 30 April 1960 and that death occurred at 5:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) DR. L. GLICK.		22d. ADDRESS 126 N. Smallwood St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/6/60	23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cem.	23d. LOCATION (City, town or county) (State) Cumberland Md.
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE May 9 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5211

CERTIFICATE OF DEATH

05208

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 HR. 45 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) ORNISHMORAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GRACE	Middle ---	Last COX
4. DATE OF DEATH	Month MAY	Day 13	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH NOV. 22, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) PATTERSON CREEK, W.VA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SEYMOUR BALDWIN		14. MOTHER'S MAIDEN NAME MARY ABE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL
		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 4 Hours			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease 54% (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old Aortic Valvular Deformity			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 While Not while p. m. at work <input type="checkbox"/> at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19____, that (II) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
22a. SIGNATURE H. Weisman		M.D. ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/19/60
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/60	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	25a. REC'D BY REGISTRAR DATE MAY 18 '60
		25b. REGISTRAR'S SIGNATURE Arthur S. Haas	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5212

CERTIFICATE OF DEATH

05209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11 mo., 14 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First Charles	Middle Grover
Last Crawford		4. DATE OF DEATH May 23	Month 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/4/85
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY City of Cumberland	11. BIRTHPLACE (State or foreign country) Burlington, W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Crawford	
14. MOTHER'S MAIDEN NAME Melissa Jane Moore		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 213-24-6448		17. INFORMANT Institution Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331 Cerebral Hemorrhage.		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422 Myocardial Degeneration		?	
DUE TO (b) 422 Myocardial Degeneration		?	
DUE TO (c) 450 General arteriosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 322 Chronic Alcoholism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1st, 1959 to May 23rd, 1960 , that I last saw the deceased alive on May 23rd, 1960 , and that death occurred at M. , from the causes and on the date stated above. ACTUAL SIGNATURE James E. McLean, M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED James E. McLean, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 26, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.		24a. REC'D BY REGISTRAR DATE MAY 31 '60	
		24b. REGISTRAR'S SIGNATURE John J. Hafer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01-380M172A8-PT1A5K98 9/3/1976 100 STATE 9/11/2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital - D. O. A.		d. STREET ADDRESS 29 Poplar St. Bowling Green		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joann	Middle Bonita	Last Crawford	4. DATE OF DEATH	Month May	Day 28	Year 1960
5. SEX	6. COLOR OR RACE Female White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 14, 1960	9. AGE (In years last birthday) yrs. 1 14	10. UNDER 1 YEAR Months 1	Days 14	IF UNDER 24 HRS. Hours Min. 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles E. Crawford				14. MOTHER'S MAIDEN NAME Joyce Beedle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. C. E. Crawford, Bowling Green		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AORTIC STENOSIS, PATENT FORAMEN OVALE INTERVAL BETWEEN ONSET AND DEATH since birth							
754.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGENITAL ANOMALY -----							
DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
ASPIRATION OF STOMACH CONTENTS, MINIMAL, TERMINAL							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				DATE SIGNED MAY 28, 1960			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 31, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Restlawn Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR John S. Krause	24b. REGISTRAR'S SIGNATURE Charles L. Krause
						DATE May 31, 1960	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5214

CERTIFICATE OF DEATH

05211

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT		d. STREET ADDRESS 108 E. HAMPSHIRE STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		85X-3	
3. NAME OF DECEASED (Type or print)	First ETTA	Middle E	Last DAVIS	4. DATE OF DEATH MAY 23 1960	Month MAY	Day 23	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 23, 83	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHRISTOPHER HOTI		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME HARRIET, GERARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } } DUE TO (c) } <i>Chronic Myocarditis</i> <i>Arteriosclerosis</i> <i>Bravosea of age</i>							
INTERVAL BETWEEN ONSET AND DEATH 3 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Allegy Md		20f. (City or town) (County) (State) Cumberland Allegy Md	
21. I certify that (I) (this hospital) attended the deceased from 5/5/60 to 5/23/60 , that (I) (we) last saw the deceased alive on 5/5/60 , and that death occurred at 2:20 AM the causes and on the date stated above.							
22. SIGNATURE R. J. Williams				22b. DATE SIGNED May 25, 1960			
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 SO. CENTRE STREET, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 25/60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Philos Cemetery Piedmont, W. Va.		23d. LOCATION (City, town, or county) (State) Westernport, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.H. Fredrik Jr.		25a. REC'D BY REGISTRAR DATE MAY 31 '60					
		25b. REGISTRAR'S SIGNATURE Arthur S. Price					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5215

CERTIFICATE OF DEATH

05212

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 WESTERNPORT		d. STREET ADDRESS HILL TOP		
d. NAME OF HOSPITAL OR INSTITUTION (Hospital, name and address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First HOWARD	Middle J.	Last DAVIS	4. DATE OF DEATH MAY 28	Month	Day	Year 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 17		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Farmer				
11. BIRTHPLACE (State or foreign country) MAYSVILLE, W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME GEORGE DAVIS				14. MOTHER'S MAIDEN NAME VINEY VICTORIA KEPLINGER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, Address CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident (Embolus)</u> INTERVAL BETWEEN ONSET AND DEATH 430. 3 days DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) <u>Auricular Fibrillation</u> ?? DUE TO (c) <u>Coronary arterial sclerosis; Myocardial fibrosis</u> ??								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Uremia; Peripheral vascular insufficiency, right 19. WAS AUTOPSY PERFORMED? 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 17, 1960, to May 28, 1960, that (II) (we) last saw the deceased alive on May 27, 1960, and that death occurred at 15 AM from the causes and on the date stated above.								
22a. SIGNATURE <i>Samuel M. Jacobson, M.D.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 28, 1960		
22c. PHYSICIAN'S NAME (Type) SAMUEL M. JACOBSON, M. D.		22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/60		23c. NAME OF CEMETERY OR CREMATORIAL Lahmansville Cem.		23d. LOCATION (City, town, or county) Lahmansville, W.Va. (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer B. Smith</i>		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUN 3 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thorne</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5218 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05213

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Washing	Last Dayton
4. DATE OF DEATH	Month May	Day 22	Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 26, 1878
9. AGE (In years last birthday 81 yrs.)		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George W. Dayton		14. MOTHER'S MAIDEN NAME Fanny Cole	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address Marshall Dayton-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gangrene of bowel DUE TO (c) Strangulated hernia			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
3 days			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
20g. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20h. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED May 22, 1960		
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/24/60	22c. NAME OF CEMETERY OR CREMATORIALY Philos	22d. LOCATION (City, town, or county) Westernport, (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>El Boral</i>	ADDRESS Westernport, Md.	24o. REC'D BY REGISTRAR MAY 25 60	24b. REGISTRAR'S SIGNATURE <i>Arthur J. Moore</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

EXAMINER CERTIFICATE OF DEATH
STATE OF HAWAII - SAILOR

Journal of Clinical Endocrinology

• 100 •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5292

CERTIFICATE OF DEATH

(15214
Reg. Off. No.)

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 9 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Barton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH Month May Day 4 Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 8, 1888	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Penn.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Edward Deniker		14. MOTHER'S MAIDEN NAME Not Known			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-2009		17. INFORMANT Alta D. Preston-Barton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degeneration Not specified as Rheumatic		DUE TO Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1		DUE TO (b) Arteriosclerosis		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) March 5, 1960		(County) Salisbury (State) Md.	
21. I certify that I attended the deceased from March 5, 1960 , to May 4, 1960 , that I last saw the deceased alive on May 3, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Paul R. Wilson, M.D. 11 Ashfield St. Piedmont W. Va. 5-5-60					
DATE SIGNED					
ACTUAL SIGNATURE Paul R. Wilson					
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/60		22c. NAME OF CEMETERY OR CREMATORIUM Salisbury Cemetery	
22d. LOCATION (City, town, or county) Salisbury, Pa.					
(State)					
23. FUNERAL DIRECTOR'S SIGNATURE E. Rival		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ALABAMA - DEPARTMENT OF REVENUE
CERTIFICATE OF DEATH

505

RECEIVED

RECEIVED
RECEIVED

RECEIVED

RECEIVED
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5217

CERTIFICATE OF DEATH

05215

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. STREET ADDRESS 328 FAYETTE STREET	
3. NAME OF DECEASED (Type or print) JOHN RANDOLPH		First Middle Last	4. DATE OF DEATH DICK SR. Month Day Year MAY 4 1960
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 26, 1872
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME WILLIAM LIVINGSTON DICK		14. MOTHER'S MAIDEN NAME JANE PATRICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-5002	17. INFORMANT Mrs. John Dick, 328 Fayette St.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO Osteoarthritis Myocardial Degeneration Coronary Artery Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. (County) (State)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 9/1 1960 to 5/4 1960 , that (I) (we) last saw the deceased alive on 9/3 1960 , and that death occurred 5/4 1960 from the causes and on the date stated above.		22b. DATE SIGNED 5/4/60	
22c. PHYSICIAN'S NAME (Type) DR. L.H. LEY		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 456 N CENTER STREET
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 6, 1960	23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE MAY 9 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

1151

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5218

CERTIFICATE OF DEATH

05216

1. PLACE OF DEATH o. COUNTY ALLEGANY			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND			b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND						
d. NAME OF HOSPITAL (If not a hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.			e. STREET ADDRESS 1217 FREDERICK ST.				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First LELIA	Middle A.	Last DICKERHOOF	4. DATE OF DEATH Month MAY	Month 18	Day 19	Year 60		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 11, 1890	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JOSEPH DEATELHAUSER			14. MOTHER'S MAIDEN NAME MARY J. VALENTINE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 212-24-034		17. INFORMANT MEMORIAL HOSPITAL	Address CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 442X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. (b)			Chronic Hypertension Cardia Vascular Rayl disease (Arteria)			INTERVAL BETWEEN ONSET AND DEATH Since 1955				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)		
21. I certify that (I) (this hospital) attended the deceased from 3-20-1959 to 5-18-1960, that (I) (we) last saw the deceased alive on 5-18-1960, and that death occurred at 6:22 PM from the causes and on the date stated above.										
22a. SIGNATURE W.F. Williams M.D.					22b. DATE SIGNED 5-20-60					
22c. PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS					22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/21/60		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cem.		23d. LOCATION (City, town, or county) Cumberland MD				
24. FUNERAL DIRECTOR'S SIGNATURE Lewis Stein Inc.			ADDRESS Cumb. MD		25a. REC'D BY REGISTRAR MAY 23 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be signed by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5219

CERTIFICATE OF DEATH

05217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>memorial Hospital</i>		d. STREET ADDRESS <i>1606 Greene St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Samuel</i>	Middle <i>David</i>	Last <i>Drobeck</i>	4. DATE OF DEATH Month <i>May</i>	Day <i>21</i>	Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Aug. 26, 1892</i>	9. AGE (In years lost, birthday) <i>67 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Consolidate Home Equipment Corp</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Drobeck</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes W.M.T.</i>		16. SOCIAL SECURITY NO. <i>214-05-4688</i>		17. INFORMANT <i>Evelyn H. Drobeck</i>		Address <i>606 Greene St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute left ventricular failure</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
<i>420</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Acute anterior myocardial infarction</i>		DUE TO (b) <i>Acute anterior myocardial infarction</i>				2 days	
		DUE TO (c) <i>Coronary occlusion</i>				2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Paroxysmal auricular tachycardia</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
19							
21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>60</u> , to <u>May 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>60</u> , and that death occurred at <u>9:12 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>50 Pershing Street</i>							
ACTUAL SIGNATURE <i>Samuel Jacobson</i>	M.D.	DATE SIGNED <i>5/24/60</i>					
PHYSICIAN'S NAME (Type) <i>Samuel M. Jacobson, M. D.</i>	Cumberland, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 24, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>S.S. Peter & Paul Cem.</i>	22d. LOCATION (City, town, or county) <i>Cumberland Md.</i>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein, Inc.</i>	ADDRESS <i>Cumberland, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAY 26 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2816

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

CITY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5293 CERTIFICATE OF DEATH

05218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie	
3. NAME OF DECEASED (Type or print) Charles Leroy Emerick		First Charles	Middle Leroy
		Last Emerick	4. DATE OF DEATH May 2, 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 1, 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY B&O Shops	
13. FATHER'S NAME Sylvester Emerick		14. MOTHER'S MAIDEN NAME Jeannette Speelman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-16-2211	
		17. INFORMANT Mrs. C.L.Emerick, Ellerslie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA, CEREBRAL		2 WEEKS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last! 162.1			
(b) BRONCHOGENIC CARCINOMA		6 MOS ?	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC , 19 59 , to MAY , 19 60 , that I last saw the deceased alive on 30 APRIL , 19 60 , and that death occurred at 5:30PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE W. L. Emerick & Daughters		DATE SIGNED 5/3/60	
PHYSICIAN'S NAME (Type) WILLIAM P. JAMES, M.D.		CUMBERLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Palo Alto Cemetery		22d. LOCATION (City, town, or county) Hyndman, Pa. RD#1 (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lawrence L. Engler		24a. REC'D BY REGISTRAR DATE MAY 5 '60	
		24b. REGISTRAR'S SIGNATURE W. L. Emerick & Daughters	

1

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5220

CERTIFICATE OF DEATH

05219

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE		e. STREET ADDRESS 500 LINDEN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ROBERT ANDREW ENDRES		First	Middle
4. DATE OF DEATH MAY 15, 1960		Last	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MARCH 25, 1960
9. AGE (In years last birthday) yrs. 1	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 762.5	10b. KIND OF BUSINESS OR INDUSTRY WIDOWED	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME ELMER ENDRES		
14. MOTHER'S MAIDEN NAME DORIS ANN NAVE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Elmer Endres	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity and Atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Treascher Collins Syndrome			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at 11:20 AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>H. Hashim</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1960
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/60	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS P O S of A Cemetery
23d. LOCATION (City, town, or county) Centerville		(State) Penna	
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		25a. REC'D BY REGISTRAR DATE MAY 19 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

30-17

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5221

CERTIFICATE OF DEATH

05220

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 29 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SHERIDAN		First SHERIDAN	Middle EVANS
Last EVANS		4. DATE OF DEATH MAY 14 1960	Month Day Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 22 1881
9. AGE (In years lost birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	11. BIRTHPLACE (State or foreign country) ELK GARDEN, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DAVID EVANS	
14. MOTHER'S MAIDEN NAME ARMEDA KESSEL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT WARWICK & MEMORIAL AVENUE, MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) NEPHROSCLEROSIS			
DUE TO (c) Hypertensive Cardiovascular Disease			
INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6:00 A.M. MAY 14 1960 that (I) (we) last saw the deceased alive on MAY 13 1960 , and that death occurred at M , from the causes and on the date stated above.			
22o. SIGNATURE A. Weisman		22b. DATE SIGNED 5/14/60	
22c. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN		M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/60	
23c. NAME OF CEMETERY OR CREMATORIAL Philos		23d. LOCATION (City, town, or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. Boral		ADDRESS Westernport, Md.	25o. REC'D BY REGISTRAR DATE MAY 17 '60
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

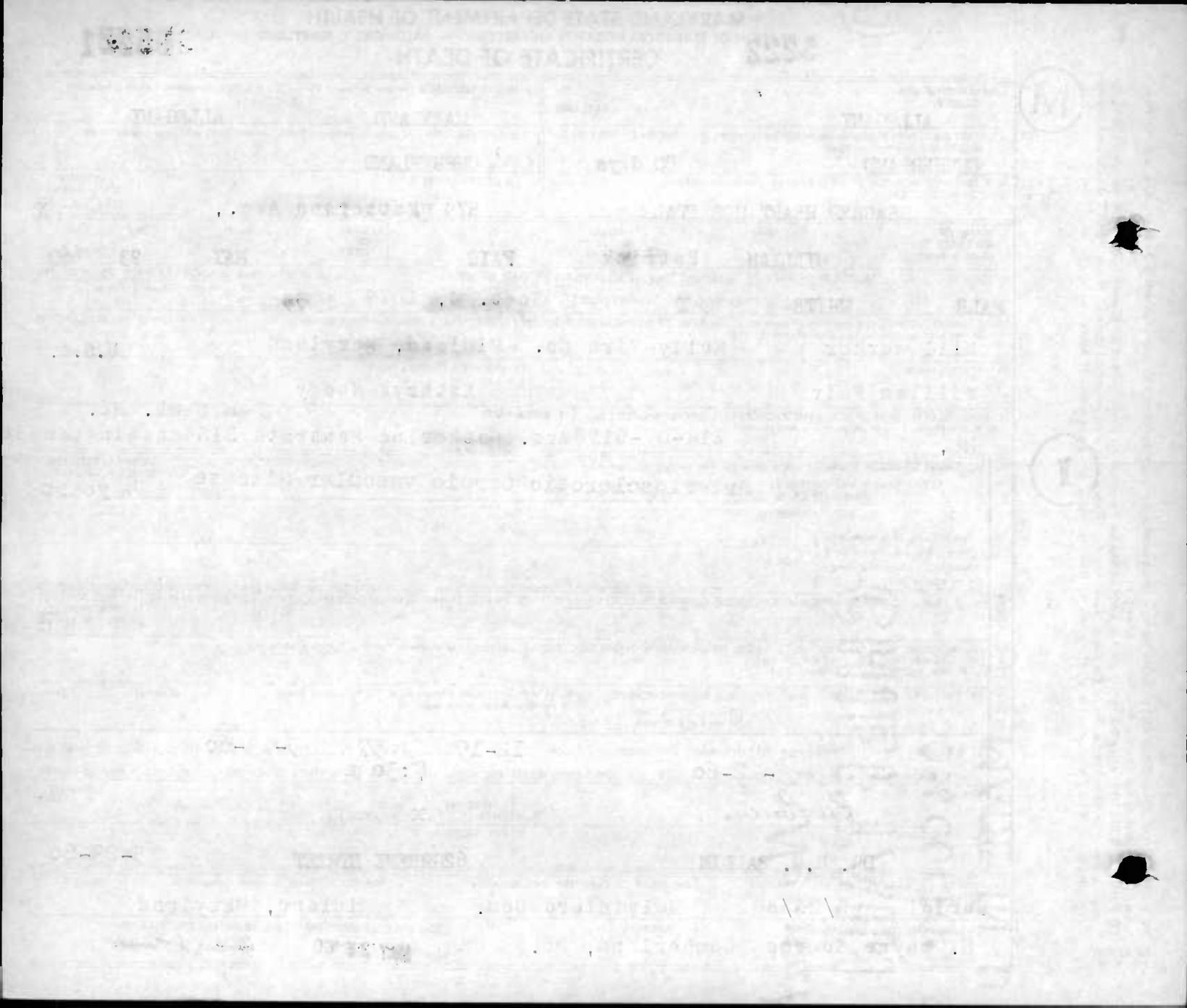
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5222

05221

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 80 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle Patrick	Last FAIR			
4. DATE OF DEATH			Month MAY	Day 23	Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1879	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill worker	10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.	11. BIRTHPLACE (State or foreign country) Midland, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Fair	14. MOTHER'S MAIDEN NAME Kathryn Moody					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. 214-07-0198	17. INFORMANT Mrs. Catherine Hausrath	Address Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio vascular disease			INTERVAL BETWEEN ONSET AND DEATH 4 years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						
DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Midland	(County) Maryland	(State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 12-19 19 57 to 5-23-60 19, that (I) (we) last saw the deceased alive on 5-22-60 19, and that death occurred at 7:30 p.m. from the causes and on the date stated above.						
22a. SIGNATURE R.W. Ballin			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> <input type="checkbox"/> STAFF PHYS.	22b. DATE SIGNED 5-23-60		
22c. PHYSICIAN'S NAME (Type) DR. R.W. BALLIN			22d. ADDRESS 62 GREENE STREET			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/25/60	23c. NAME OF CEMETERY OR CREMATORIAL Belvidiere Cem.	23d. LOCATION (City, town, or county) Midland, Maryland (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George			ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR May 25 60	25b. REGISTRAR'S SIGNATURE Charles S. Haas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05223
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 542 Fort Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First CARTER	Middle HENRY	Last GALLIHER			
4. DATE OF DEATH	MAY 28	Month 8	Day 19			
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 28, 1903			
9. AGE (In years from birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 56	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith Helper	10b. KIND OF BUSINESS OR INDUSTRY B& O Railroad	11. BIRTHPLACE (State or foreign country) Morgan County, West Virginia	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SAMUEL B. GALLIHER	14. MOTHER'S MAIDEN NAME MARY ELLEN FAHEY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 705-07-9679	17. INFORMANT Mrs. Evelyn Galliher	Address 542 Fort Avenue Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to Hanging INTERVAL BETWEEN ONSET AND DEATH 10 MIN.						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 974X		DUE TO (b)				
		DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 8 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Cumberland	(County) Allegany	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE Benedict Skitarelic				DATE SIGNED May 8, 1960		
EXAMINER'S NAME (Type) Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/60		22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D. BY REGISTRAR MAY 16 '60		24b. REGISTRAR'S SIGNATURE John J. Hafer
				DATE		

REGULATORY EXAMINER CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5224

CERTIFICATE OF DEATH

05223
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
Allegany MARYLAND		Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cumberland		02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
222 Wills Creek Ave	222 Wills Creek Ave		
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	Frank		Gellner
4. DATE OF DEATH	Month	Day	Year
	May	26	1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug 5, 1883
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Glass Blower	Mfg. Glass ware	Cumberland, Maryland	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John M. Gellner	Anna M. Miller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	219-03-8122	Mrs. Rita V. Burke	Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		16 days	
163X		to Month	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE	M.D. 16 Glencoe St, Cumberland, Md.		11/5/60
POLICE SIGNATURE			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	May 30, 1960	SS Peter & Paul Cem.	Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Louis Stein, Inc.	Cumberland, Md.	MAY 31 60	John S. Hunt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5225 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05224

R 65884

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb 48 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Triple Lake R.D. #5 d. STREET ADDRESS Triple Lake e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Daniel First John Middle Haan		4. DATE OF DEATH May 21 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1889
			9. AGE (In years at birth) 70 yrs.
			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Inspector
			11. KIND OF BUSINESS OR INDUSTRY Planing Mill
			12. BIRTHPLACE (State or foreign country) Luxenbourg, Grand Dutches USA
13. FATHER'S NAME Michael Haan		14. MOTHER'S MAIDEN NAME Teresa Ingle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-05-6952	17. INFORMANT Elsie E. Haan Address Triple Lake, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 DUE TO CORONARY OCCLUSION INTERVAL BETWEEN ONSET AND DEATH Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CORONARY SCLEROSIS (c) 24 ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.			
MEDICAL CERTIFICATION ACTUAL SIGNATURE Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 21, 1960
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-24-60	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS James F. Scarpelli	24a. REC'D BY REGISTRAR DATE MAY 24 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1-2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5226 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05225
 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Allegany		a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 30 W. First Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print)		First OLLIE	Middle VIRGINIA
		Last HAENFTLING	4. DATE OF DEATH May
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH June 26, 1915		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) West Virginia
13. FATHER'S NAME Sylvester George		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT L. Raymond George
		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED MAY 18, 1960	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF May 20, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olive Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAY 23 '60
			24b. REGISTRAR'S SIGNATURE <i>Arthur E. Haas</i>

EDUCATIONAL INSTITUTIONS CREATE GREAT STAFF AGREEMENTS OF HEART-HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G263 5-20-60 et

05226

5227

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 25yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 319 Broadway			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 319 Broadway				d. STREET ADDRESS 319 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John L. Harden		First	Middle	Lost	4. DATE OF DEATH May 17, 1960	Month	Day	Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept 15, 1895	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance Hospital		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Perry Harden		14. MOTHER'S MAIDEN NAME Celia Kelly							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-8727		17. INFORMANT Lillian Harden 319 Broadway		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 6 mo									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriovenous heart disease (c) interstitial 1 year									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 52 Green St.		(County) Cumberland, Md.	(State) Md.
21. I certify that I attended the deceased from 4-3 , 19 59 , to 5-17 , 19 60 , that I last saw the deceased alive on 5-15 , 19 60 , and that death occurred at M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 52 Green St., Cumberland, Md. DATE SIGNED									
ACTUAL SIGNATURE L. Brings									
PHYSICIAN'S NAME (Type) Lewis Brings		57 Green Street		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-20-60		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR MAY 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF HAWAII
CERTIFICATE OF DEATH

DECEASED'S NAME	DATE OF DEATH	AGE AT DEATH
MR. JAMES W. DUNN	APRIL 10, 1950	50
ADDRESS	STATE	CITY
101 KAHALA AVENUE	HAWAII	KAHALA
NAME AND ADDRESS OF DOCTOR	NAME AND ADDRESS OF FUNERAL DIRECTOR	
DR. RICHARD L. COOPER 101 KAHALA AVENUE	MURRAY FUNERAL HOME 101 KAHALA AVENUE	
NAME OF PERSON FILING THIS CERTIFICATE	RELATIONSHIP TO DECEASED	
JOHN W. DUNN	SPOUSE	
ADDRESS	STATE	CITY
101 KAHALA AVENUE	HAWAII	KAHALA
NAME OF PERSON SIGNING	RELATIONSHIP TO DECEASED	
JOHN W. DUNN	SPOUSE	
ADDRESS	STATE	CITY
101 KAHALA AVENUE	HAWAII	KAHALA
DATE	TIME	
APRIL 10, 1950	10:00 A.M.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5229 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05227

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 65 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle NEVIN	Last HAY
4. DATE OF DEATH	Month May	Day 22	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1875
9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR Months yrs.	11. IF UNDER 24 HRS. Hours Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookeeper	10b. KIND OF BUSINESS OR INDUSTRY Dairy	11. BIRTHPLACE (State or foreign country) Nebraska	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Calvin Hay		14. MOTHER'S MAIDEN NAME Drucilla DeVore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214 05 4548	17. INFORMANT Mrs. John Carroll	Address Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, Left DUE TO 443X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular disease DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 23, 1960
EXAMINER'S NAME (Type) Benedict Skitarelic			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25, 1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Patricks Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR MAY 24 '60
			24b. REGISTRAR'S SIGNATURE Charles S. Trahan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

PHYSICAL EXAMINER CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

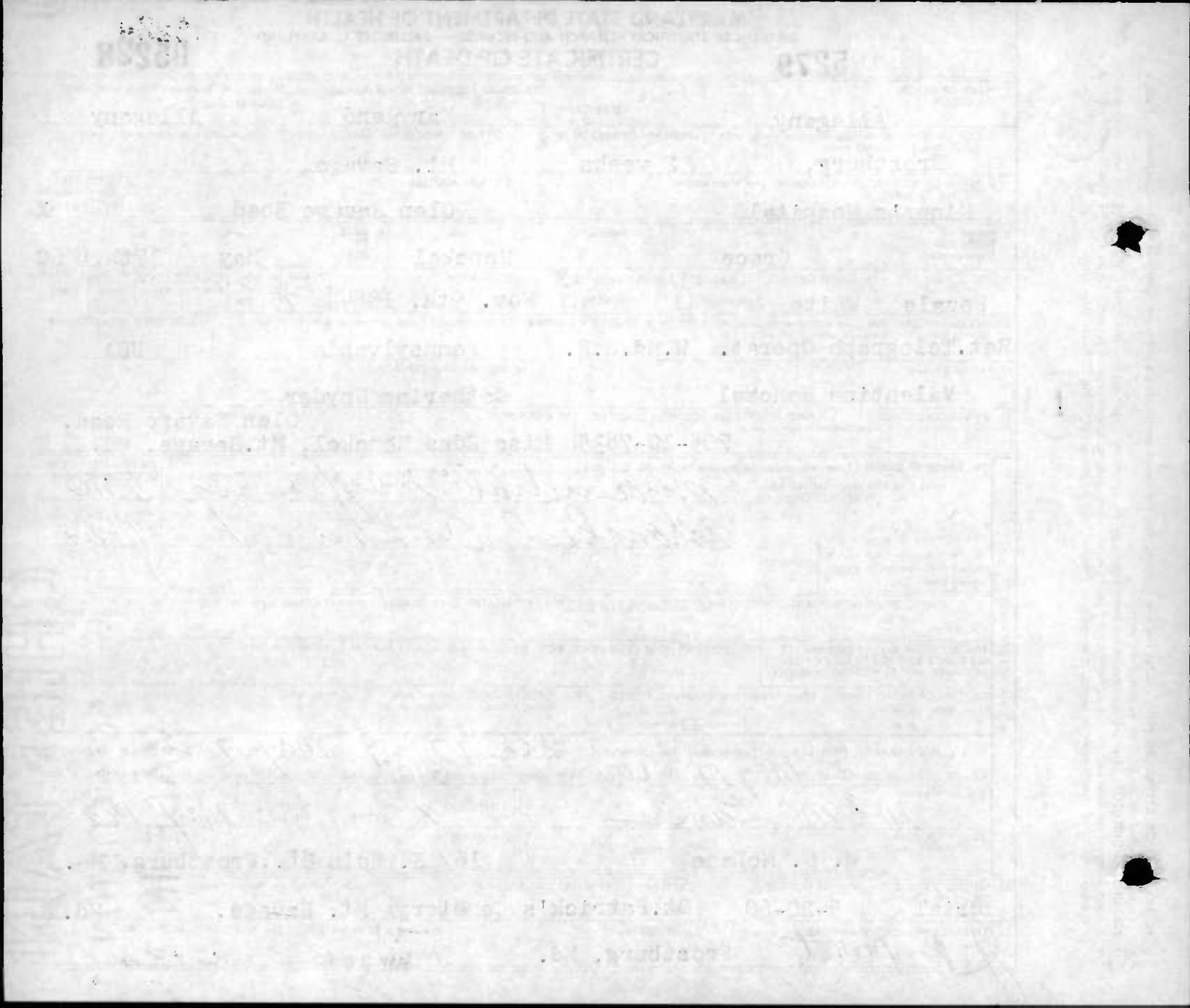
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5279

CERTIFICATE OF DEATH

05228

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg,		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage,				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS Glen Savage Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Grace		First	Middle	Last	4. DATE OF DEATH Henckel	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 9th, 1884	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Telegraph Operat.		10b. KIND OF BUSINESS OR INDUSTRY W.Md.R.R.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Valentine Henckel		14. MOTHER'S MAIDEN NAME Catherine Snyder						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 705-10-7835		17. INFORMANT Miss Edna Henckel, Mt. Savage, Md.		Glen Savage Road, <i>addr.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 24IX		DUE TO Myocardial Insufficiency		INTERVAL BETWEEN ONSET AND DEATH 3 mo				
Conditions, if any, which give rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO Bronchial Asthma		many years				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Dec 17, 1959 to May 17, 1960 , that (I) (we) last saw the deceased alive on May 17, 1960 and that death occurred at 11 AM , from the causes and on the date stated above.								
22a. SIGNATURE W. O. McLane		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 1960				
22c. PHYSICIAN'S NAME (Type) W. O. McLane		22d. ADDRESS 167 E. Main St., Frostburg, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-20-60		23c. NAME OF CEMETERY OR CREMATORIAL St. Patrick's Cemetery		23d. LOCATION (City, town, or county) Mt. Savage, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		ADDRESS Frostburg, Md.		25a. REC'D BY REGISTRAR Chetina S. House		25b. REGISTRAR'S SIGNATURE		
				DATE MAY 20 '60				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5229

CERTIFICATE OF DEATH

05229
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 90 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 228 Pear Street		d. STREET ADDRESS 228 Pear Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY ELIZABETH HERPICH		First	Middle	Last	4. DATE OF DEATH May 20	Month	Day	Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 23, 1863	9. AGE (In years last birthday) 97 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edward Rice			14. MOTHER'S MAIDEN NAME Caroline ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Lester Barnes		Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) } DUE TO } (c) DUE TO } (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 25 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m. 19		Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 236 W. 1st	(County) Cumberland	(State) Md.		
21. I certify that I attended the deceased from June 1954 to May 20, 1965 that I last saw the deceased alive on May 10, 1965 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Clay J. Burnett M.D. ADDRESS (Street, city or town, state) 236 W. 1st Cumberland, Md. DATE SIGNED 5/21/60									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md. (State)				
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE MAY 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

SEARCHED	INDEXED	SERIALIZED	FILED
DECEASED PERSON			
NAME			
ADDRESS			
AGE			
SEX			
MATERIAL TESTED			
TESTS			
CAUSE OF DEATH			
TIME OF DEATH			
PLACE OF DEATH			
DEATH CERTIFIED			
SIGNATURE			
STAMP			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

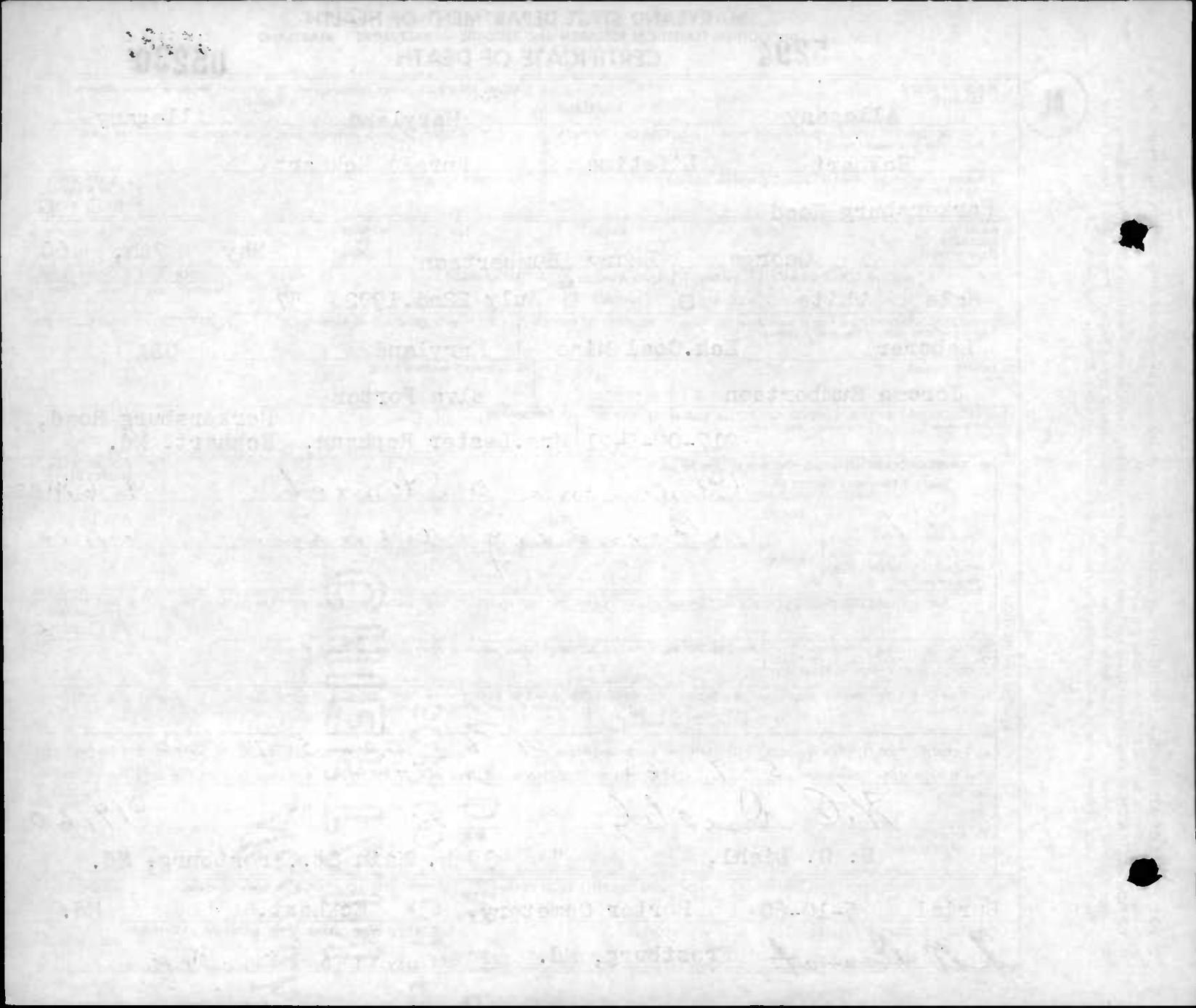
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5294

CERTIFICATE OF DEATH

05230

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Eckhart	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Parkersburg Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		First	Middle
		Last	4. DATE OF DEATH Month May
		Day 7th	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 22nd, 1902
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Eck. Coal Mine	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Jerome Humbertson		14. MOTHER'S MAIDEN NAME Elva Porter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. 217-09-5421	17. INFORMANT Mrs. Lester Rephann,
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO (d) DUE TO	
		Cancer of Stomach. Secondary anemia. INTERVAL BETWEEN ONSET AND DEATH 4-6 mos 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-1 , 19 60 , to 5-7 , 19 60 , that (I) (we) last saw the deceased alive on 5-7 , 19 60 and that death occurred at 7A M, from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE H. C. Diehl		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/9/60
22c. PHYSICIAN'S NAME (Type) H. C. Diehl,		22d. ADDRESS 39 W. Main St., Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-60	23c. NAME OF CEMETERY OR CREMATORIAL Porter Cemetery,
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Duerst		ADDRESS Frostburg, Md.	25a. REC'D BY REGISTRAR DATE MAY 11 '60
		25b. REGISTRAR'S SIGNATURE Clinton S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5230 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05231
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 45 minutes	b. COUNTY ALLEGANY	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 209 GREENE STREET	
3. NAME OF DECEASED (Type or print)	First ALFRED	Middle JACOPI	Last Month Day Year 5 2 1960

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-05	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days 2
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Grocery Owner	10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) ITALY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME ANGELO JACOPI	14. MOTHER'S MAIDEN NAME Agusta Bastiani	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Alfred Jacopi 209 Greene St.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Sclerosis with thrombosis, right		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
Also old left myocardial infarction due to sclerosis of left artery.		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
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ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED May 2, 1960
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/60	22c. NAME OF CEMETERY OR CREMATORIUM S. S. Peter & Paul's	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 4 '60	24b. REGISTRAR'S SIGNATURE <i>Charles L. George</i>

TO DEATHY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

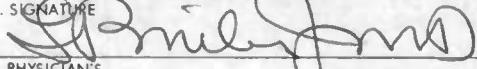
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5288

CERTIFICATE OF DEATH

05232

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Avenue		e. STREET ADDRESS Douglas Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First James	Middle Jones	4. DATE OF DEATH Month May Day 27 Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1904
9. AGE (In years lost birthday) 55 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleanerse Worker	11. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Jones	14. MOTHER'S MAIDEN NAME Rose Clark		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. James Jones "Wife"	Address Lonaconing, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Artery Disease (c) Deterioration			
INTERVAL BETWEEN ONSET AND DEATH 24 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to 5.27 1966 that (I) (we) last saw the deceased alive on 5-27 1966, and that death occurred at 9 a.m., from the causes and on the date stated above.			
22a. SIGNATURE 		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1966
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONACONING MD	
23a. BURIAL, CREMATION, (Specify) Burial	23b. DATE THEREOF 5/30/60	23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery	23d. LOCATION (City, town, or county) MOSCOW, (State) Md.
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	25a. REC'D BY REGISTRAR DAWN 1 '60
			25b. REGISTRAR'S SIGNATURE Charles S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

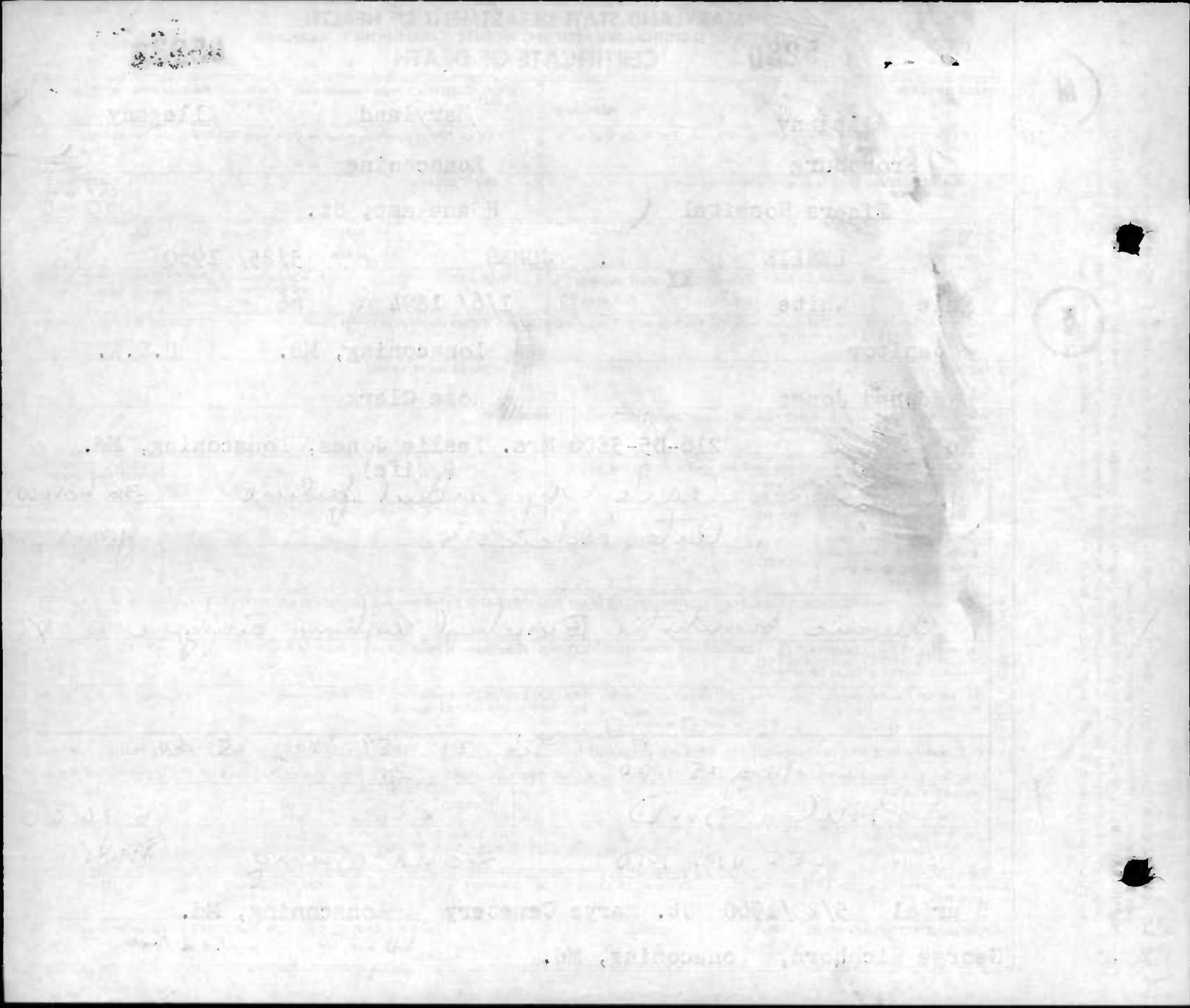
MARYLAND STATE DEPARTMENT OF HEALTH

5280 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05233

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS H anekamp, St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LESLIE	Middle M.	Last JONES
4. DATE OF DEATH	Month 5/25/ 1960	Day Year 19 19	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/ 1894
9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months 66	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Jones		14. MOTHER'S MAIDEN NAME Rose Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-05-5806	
17. INFORMANT Mrs. Leslie Jones, Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0		Acute myocardial failure 36 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO		Years	
(c)		Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Chronic bronchitis, Bronchial asthma, Emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 21 1959 to May 25 1960 , that (I) (we) last saw the deceased alive on May 25 1960 and that death occurred at 3pm , from the causes and on the date stated above.		22b. DATE SIGNED 5-26-60	
22a. SIGNATURE L.P. Miles, Jr., M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) L.P. Miles, Jr., M.D.		22d. ADDRESS Lonaconing, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/1960	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Marys Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Md.		25a. REC'D BY REGISTRAR DATE MAY 27 '60	
		25b. REGISTRAR'S SIGNATURE Arthur J. Hause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										05234			
5231					CERTIFICATE OF DEATH								
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 7 DAYS					d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If hospital, give street address) HOSPITAL MEMORIAL & WARWICK AVE.					e. STREET ADDRESS 64 BOONE STREET					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First EDWARD		Middle P.		Last KAYLOR		4. DATE OF DEATH Month MAY		Day 6	Year 1960		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 2 1897		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Formen			10b. KIND OF BUSINESS OR INDUSTRY Railroad			11. BIRTHPLACE (State or foreign country) MARYLAND Towncreek			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ADAM KAYLOR						14. MOTHER'S MAIDEN NAME ANNE LARGENT							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 710-09-6100		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Generalized Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 1 week													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) Arteriosclerosis													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) CUMBERLAND (County) MD. (State)				
21. I certify that (I) (this hospital) attended the deceased from 4/7/60 to 5/6/60 , 19, that (I) (we) last saw the deceased alive on 5/6/60 , and that death occurred at 9:00 PM , from the causes and on the date stated above.													
22a. SIGNATURE R. J. Williams						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) DR. R.J.WILLIAMS						22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-9-60		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park			23d. LOCATION (City, town, or county) Cumberland, Md.			(State)			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli						ADDRESS Cumberland, Md.			25a. REC'D BY REGISTRAR MAY 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Greene		
VR A15 (4) 15M 9/59													

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5232

CERTIFICATE OF DEATH

Reg. No. 15235

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 5/23/58	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR ALLEGANY COUNTY INFIRMIARY	d. STREET ADDRESS Nat'l Highway, Narrows Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary	First Henrietta	Middle Last Keller	4. DATE OF DEATH Month Ma Day 9 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/75	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Bender		14. MOTHER'S MAIDEN NAME Mary Gesner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	INFORMANT P.O. Box 599	Addr. Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cerebral arteriosclerosis, (c) DUE TO Chronic nephritis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile psychoses					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from 5/23/58, 19, to 5/8/60, 19, that I last saw the deceased alive on 5/8/60, 19, and that death occurred at _____, M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Dr. James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 5/9/60			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 11, 1960		22b. DATE THEREOF May 11, 1960		22c. NAME OF CEMETERY OR CREMATORIUM SS. Peter & Paul's	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 11 '60	24b. REGISTRAR'S SIGNATURE Charles L. Krause

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5233

CERTIFICATE OF DEATH

05236

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If deceased died in hospital, give hospital address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL NW&R AVENUES		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
3. NAME OF DECEASED (Type or print) ELLA		Middle Jane	Last KERNS
4. DATE OF DEATH MAY 14, 1960	Month MAY	Day 14	Year 1960
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 25, 1881
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) WEST VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Moses ROBINSON	
14. MOTHER'S MAIDEN NAME MARY MALONE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardia</i> DUE TO 422.1			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Vascular disease</i> <i>for advanced</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-4 , 19 53 , to 5-14 , 19 60 , that (I) (we) last saw the deceased alive on 5-14 , 19 60 , and that death occurred at 8:40 A.M. The causes and on the date stated above.			
22a. SIGNATURE <i>Wm. L. Williams</i>		ATTENDING MED. PHYS. <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/60	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery
23d. LOCATION (City, town, or county) Bedford Valley, Penna.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	25a. REC'D BY REGISTRAR DATE MAY 18 '60
			25b. REGISTRAR'S SIGNATURE <i>Charles S. Moore</i>

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

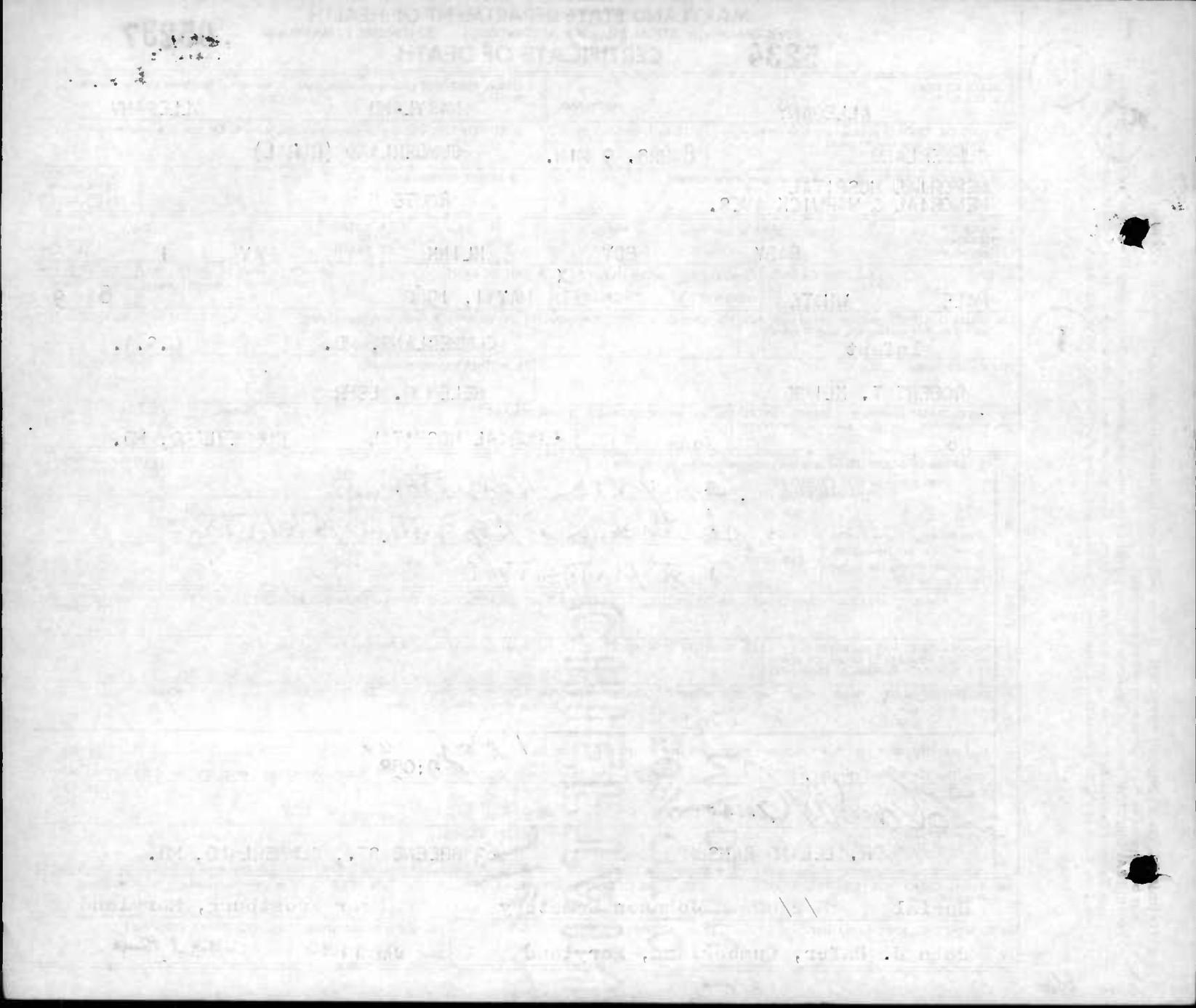
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 HRS. 9 MIN.			
d. NAME OF HOSPITAL (If died in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BABY		First BOY	Middle KLINK		
4. DATE OF DEATH MAY 1 1960	Month MAY	Day 1	Year 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 1, 1960		
9. AGE (In years last birthday) yrs. 8	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant	11. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? U.S.A.	12. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		
13. FATHER'S NAME ROBERT T. KLINK	14. MOTHER'S MAIDEN NAME HELEN G. LEHR	Address CUMBERLAND, MD.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aphyxia Neonatorum DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asthenia + Aspiration A/electasis DUE TO (c) Post Maturity? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1 May 1960	(County) —	(State) —
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred 9:05P.M. , from the causes and on the date stated above.			22. SIGNATURE Leland J. Ransom		
22c. PHYSICIAN'S NAME (Type) DR. LELAND RANSOM			22d. ADDRESS 63 GREENE ST., CUMBERLAND, MD.	22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/2/60	23c. NAME OF CEMETERY OR CREMATORIAL Johnson Cemetery	23d. LOCATION (City, town, or county) Near Frostburg, Maryland	(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	25a. REC'D BY REGISTRAR MAY 31 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Thorne		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5281

CERTIFICATE OF DEATH

05238

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS 70 S. Water Street	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Elizabeth	Last Koegel
4. DATE OF DEATH	Month May	Day 20th, 19	Year 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3rd, 1886
9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own housework	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Geis	14. MOTHER'S MAIDEN NAME Julia Lapp		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-30-1309B	17. INFORMANT J.C. Koegel, 70 S. Water St., F'bg. Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.0		INTERVAL BETWEEN ONSET AND DEATH 1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO Melanotic Carcinoma Left Ovary	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1939 , 19, to May 20, 1960 , that (I) (we) last saw the deceased alive on May 20, 1960 and that death occurred at 6:57 P.M. from the causes and on the date stated above.		22b. DATE SIGNED May 21 1960	
22a. SIGNATURE W. O. McLane		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 167 E. Main St., Frostburg, Md.
22c. PHYSICIAN'S NAME (Type) W. O. McLane,		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-60	
23c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park		23d. LOCATION (City, town, or county) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. B. Durst		25a. REC'D BY REGISTRAR ADDRESS Frostburg, Md.	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb 65 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 34 Weber Street				d. STREET ADDRESS 34 Weber Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Carl	Middle Hodgson	Last Koerner	4. DATE OF DEATH May 14 1960	Month May	Day 14	Year 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb 20, 1895	9. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months 65	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinist		10b. KIND OF BUSINESS OR INDUSTRY B & O R. R.		11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME F. S. Koerner												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-9457		17. INFORMANT Mrs. Nellie Koerner		34 Weber Street, Cumberland, Maryland		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO Coronary Thrombosis												
INTERVAL BETWEEN ONSET AND DEATH One month												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —										
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) —		(State) —		
21. I certify that (I) (this hospital) attended the deceased from 2/7/52 , 19, to 5/14/60 , 19, that (I) (we) last saw the deceased alive on 5/10/60 , 19, and that death occurred at 5/14/60 , 19, M, from the causes and on the date stated above.												
22a. SIGNATURE Richard J. Williams, M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/16/60		
22c. PHYSICIAN'S NAME (Type) Richard J. Williams, M.D.		22d. ADDRESS 122 S. Centre St. Cumberland, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/17/60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rosehill Cemetery		23d. LOCATION (City, town, or county) Cumberland		(State) Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		25a. REC'D BY REGISTRAR Arthur S. Krause		25b. REGISTRAR'S SIGNATURE Arthur S. Krause		DATE MAY 20 '60				

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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05240

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Mt Savage		d. STREET ADDRESS Old Row			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JESSIE		First	Middle	Last	4. DATE OF DEATH A. LASHBAUGH	Month	Day	Year	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-22	9. AGE (In years last birthday 37 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Harry Mills		14. MOTHER'S MAIDEN NAME Edna Cox							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Charles Robertson, Mt. Savage, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 8-10 Hrs.							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Pulmonary Edema; Pericardial Effusion							
4010 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)	Mitral Stenosis, Marked years						
		DUE TO (c)	Rheumatic Carditis and valvulitis, old. years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		DATE SIGNED May 13, 1960							
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-16-60		22c. NAME OF CEMETERY OR CREMATORIUM Methodist Cemetery		22d. LOCATION (City, town, or county) Mt. Savage (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paula H. Montesant</i>		ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR MAY 20 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

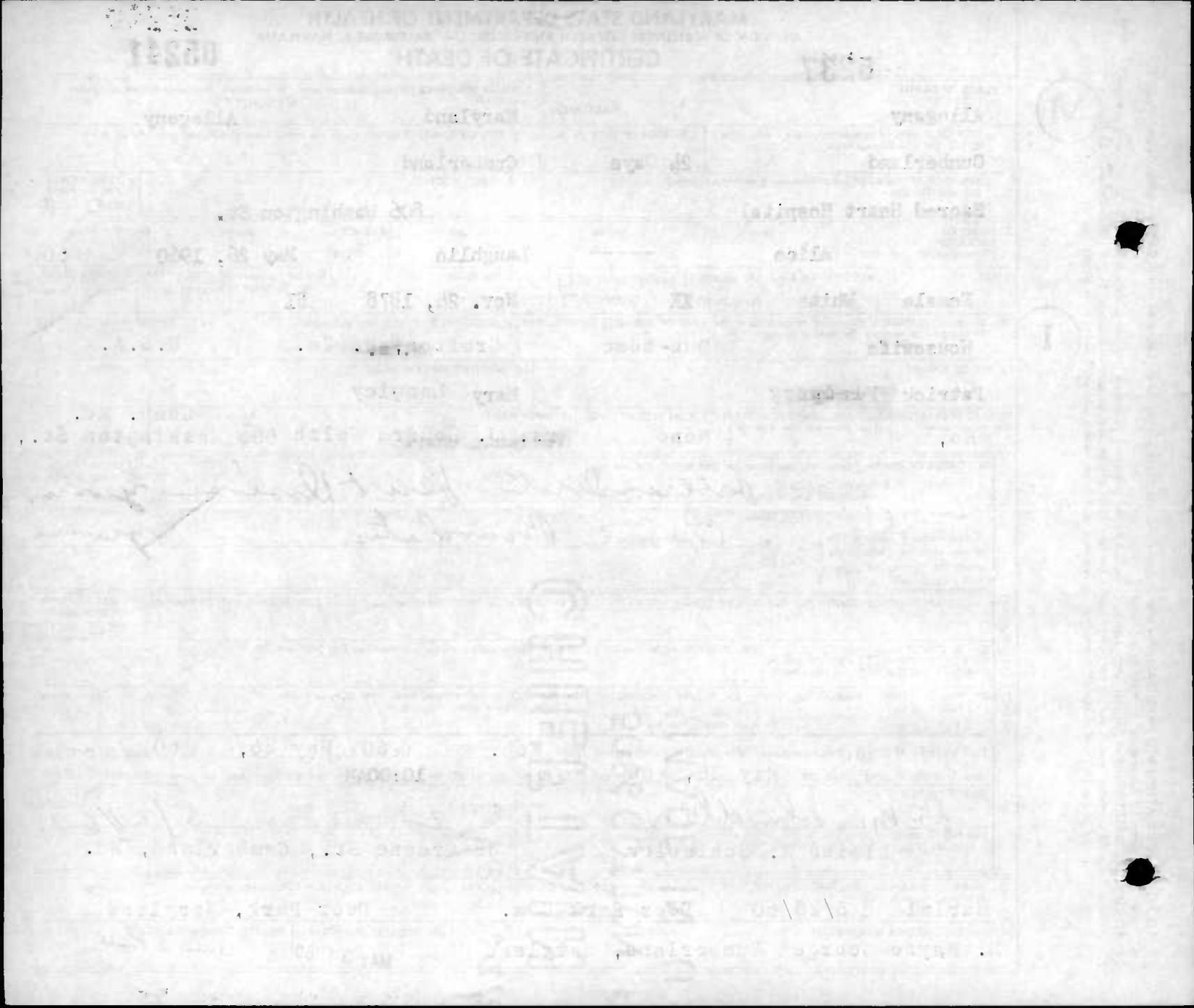
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5237

05241

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 24 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 806 Washington St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Alice	Middle -----	Last Laughlin	4. DATE OF DEATH May 26, 1960	Month 1960	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1878	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Grafton, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Flannery				14. MOTHER'S MAIDEN NAME Mary Langley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. J. Howard Welsh		Address Cumb. Md. 806 Washington St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH 420.0 years, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Bronchitis years DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 19, 60 to May 26, 1960 that (I) (we) last saw the deceased alive on May 26, 1960 , and that death occurred at 10:00 AM from the causes and on the date stated above.							
22a. SIGNATURE Blaine M. Schindler				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/27/60		
22c. PHYSICIAN'S NAME (Type) Blaine M. Schindler		22d. ADDRESS 43 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/28/60		23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cem.		23d. LOCATION (City, town, or county) (State) Deer Park, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE MAY 31 '60	25b. REGISTRAR'S SIGNATURE Charles S. Trahan



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5238 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										05242 Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 90 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			d. STREET ADDRESS 447 Columbia St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital											
3. NAME OF DECEASED (Type or print) FRANCIS E. LEWIS		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1864	9. AGE (In years last birthday) 95 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. laborer			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) West Virginia			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Lewis					14. MOTHER'S MAIDEN NAME Annie Kline						
15. WAS EVER IN U. S. ARMED FORCES? Yes Spanish-American			16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James Guthridge			Address Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured pelvis; contusion of brain										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of wheelchair									
20c. TIME OF INJURY Month, Day, Year Hour 12:35 p.m. May 10, 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Infirmary		20f. (City or town) Cumberland		(County) Allegany		(State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED May 12, 1960			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 15, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR MAY 16 '60		24b. REGISTRAR'S SIGNATURE <u>Clyburn S. Thrane</u>		DATE			

WISCONSIN STATE CHAMBER OF COMMERCE
MEDICAL EXAMINEE CERTIFICATE OF DEAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

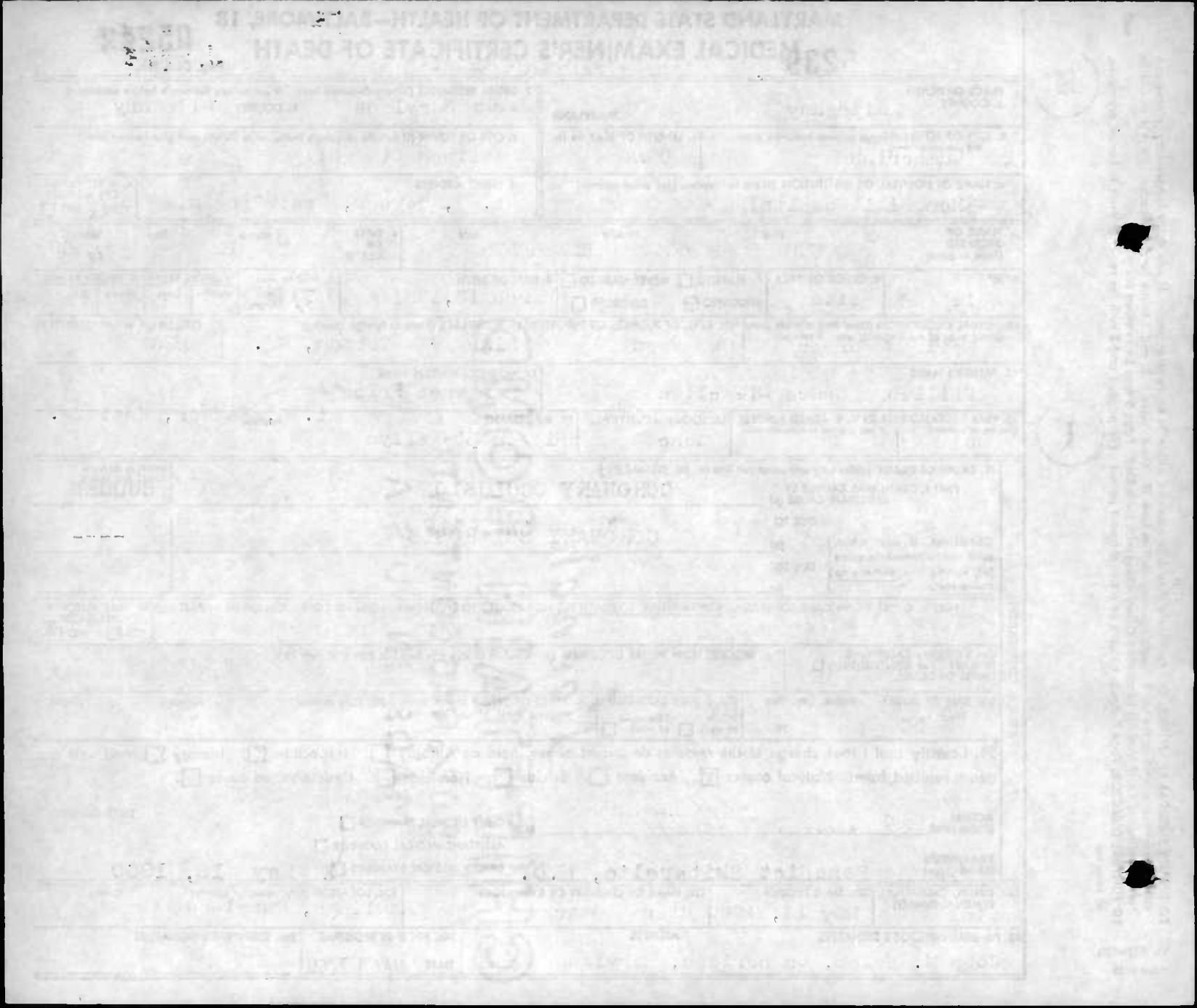
05243

Reg. Dist. No.

Item 9 FilmG263 5-20-60 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Xx Cumberland		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rawlings (Rural)	
f. STREET ADDRESS Rt. 3, Keyser, West Virginia		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BOUCE	Middle HOFFMAN	Last LLEWELLYN
4. DATE OF DEATH MAY 12 1960	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1884
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years from birthday) 77 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer	10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Black Oak Bottom, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Phillip Bruce Llewellyn		14. MOTHER'S MAIDEN NAME Margaret Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Phillip Llewellyn	Rt. 3 Address Keyser, West Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION			
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS			
DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED May 12, 1960		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 14, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Bier Cemetery	22d. LOCATION (City, town, or county) Rawlings, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 17 '60
			24b. REGISTRAR'S SIGNATURE <i>John J. Hafer</i>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5240

CERTIFICATE OF DEATH

05244
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CORRIGANSVILLE		d. STREET ADDRESS /		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ALBERT	Middle W.	Last MATTHEWS	4. DATE OF DEATH MAY 2 1960	Month MAY	Day 2	Year 1960
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 11, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee		10b. KIND OF BUSINESS OR INDUSTRY Baking		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM E. MATTHEWS		14. MOTHER'S MAIDEN NAME ANNA LOWERY MATTHEWS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-2604		INFORMANT PT'S CHART		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic Carcinoma DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 16 hrs								
10 mos								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
ADDRESS (Street, city or town, state) 141 N. Centre St DATE SIGNED 5/3/60								
21. I certify that I attended the deceased from June 1959 to May 1960 , that I last saw the deceased alive on 2 May 1960 , and that death occurred at 9:05 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE William P. James M.D. Cumberland, Maryland								
PHYSICIAN'S NAME (Type) W.P. JAMES								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Alfred Feigler		ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE MAY 5 '60		24b. REGISTRAR'S SIGNATURE Charles S. Trahan		

HEAD TO RADFORD

0856

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

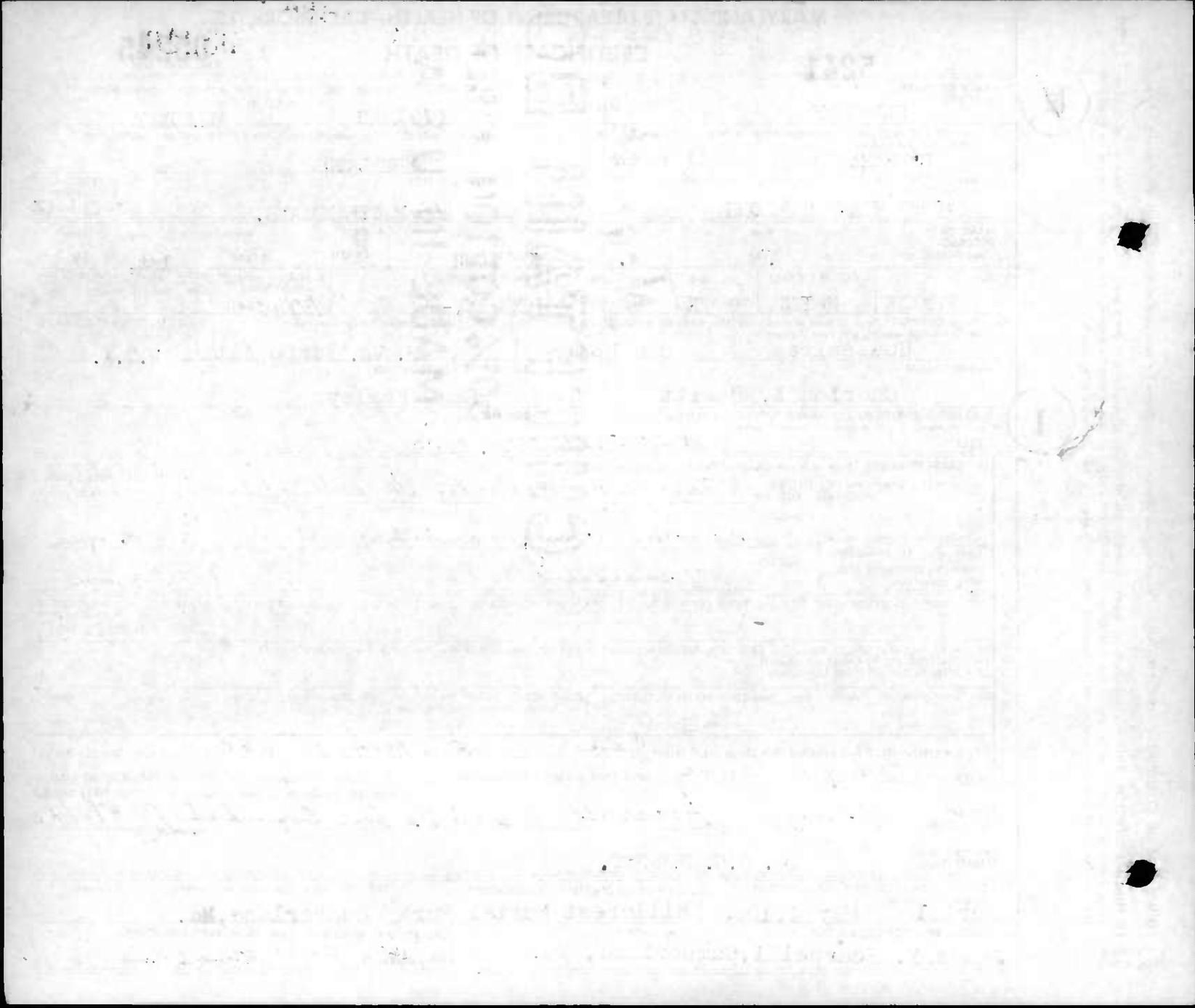
Item 9 Film G262 5/6/60 ikw
8 & CERTIFICATE OF DEATH05245
Reg. Dist. No.

5241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ADA	Middle A.	Last MCINTOSH
4. DATE OF DEATH	Month MAY	Day 1st	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 18, 1886
9. AGE (In years last birthday) 77 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. CITIZEN OF WHAT COUNTRY? W. VA. Terre Alta U.S.A.
13. FATHER'S NAME Charles L. Hewitt	14. MOTHER'S MAIDEN NAME Emma Fraley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 220-28-9683	INFORMANT PTS. CHART	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 7 yrs			
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis 5 yrs			
DUE TO (c) Thrombosis 3 mos			
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 60 , to May 1 , 19 60 , that I last saw the deceased alive on May 1 , 19 60 , and that death occurred at M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay J. Durrett ADDRESS (Street, city or town, state) M.D. 236 W. Va. Terre Cumberland DATE SIGNED 5/1/60			
PHYSICIAN'S NAME (Type) DR. C.E. DURRETT.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 4, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS	24a. REC'D BY REGISTRAR MAY 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5242 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05246**

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 159 Polk Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Louis	Middle 	Last 4. DATE OF DEATH McKenzie, Sr PEATH
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 6th, 1887
9. AGE (In years last birthday 72 yrs.)		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Elev. Operator		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jeremiah McKenzie		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-09	
17. INFORMANT James A. McKenzie, Mt. Savage, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1			
(b) Coronary Sclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 5, 1960		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-7-60	22c. NAME OF CEMETERY OR CREMATORIUM St. Patrick's Cemetery	22d. LOCATION (City, town, or county) Mt. Savage, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. P. Duest</i>	ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE MAY 9 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

THE PRACTICAL EXAMINER'S GUIDE TO THE USE OF THE STERLING

— 1 —

10

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if my event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05247
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	c. LENGTH OF STAY IN lb LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 68 MECHANIC STREET	e. STREET ADDRESS 68 MECHANIC STREET	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARGARET	First E.	Middle MCKENZIE	4. DATE OF DEATH Month MAY Day 2, Year 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 3, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HARMON WINNER	14. MOTHER'S MAIDEN NAME IDA HANSEL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. NONE	17. INFORMANT GORA MCKENZIE, FROSTBURG, MD.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900. Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO Fracture Both Bones Left Leg.						
INTERVAL BETWEEN ONSET AND DEATH Sudden - 8 Days						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell Down Flight of steps at her Home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. Apr 26 1960	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Her Home	20f. (City or town) Frostburg Allegany Md.	(County) Allegany	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE W. O. McLane	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED May 3 1960		
EXAMINER'S NAME (Type) W. O. McLANE, M. D.						
22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAY 5, 1960	22c. NAME OF CEMETERY OR CREMATORIUM ST. ANN'S CEMETERY	22d. LOCATION (City, town, or county) AVILTON, MD.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Hunter	ADDRESS FROSTBURG, MD.	24a. REC'D BY REGISTRAR DATE MAY 6 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			
VS. A15ME SM 2/57						

STATE OF
TEXAS



DEPARTMENT OF PUBLIC SAFETY - DIVISION OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ROBERT L. KELLY

DECEASED PERSON'S NAME

DEATH DATE

PLACE OF DEATH

CITY, STATE

NAME AND ADDRESS OF
MEDICAL EXAMINER

CITY, STATE

NAME AND ADDRESS OF
LABORATORY

CITY, STATE

NAME AND ADDRESS OF
CORONER

CITY, STATE

NAME AND ADDRESS OF
ATTORNEY

CITY, STATE

NAME AND ADDRESS OF
POLICE DEPARTMENT

CITY, STATE

NAME AND ADDRESS OF
FIRE DEPARTMENT

CITY, STATE

NAME AND ADDRESS OF
EMERGENCY ROOM

CITY, STATE

NAME AND ADDRESS OF
AMBULANCE SERVICE

CITY, STATE

NAME AND ADDRESS OF
HOSPITAL

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LABORATORY

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POLICE DEPARTMENT

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FIRE DEPARTMENT

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EMERGENCY ROOM

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POLICE DEPARTMENT

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NAME AND ADDRESS OF
FIRE DEPARTMENT

CITY, STATE

NAME AND ADDRESS OF
EMERGENCY ROOM

CITY, STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5243

CERTIFICATE OF DEATH

05248

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosina		First Middle Last R. M. Bailey	4. DATE OF DEATH Month Day Year 5 11 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10-10-1891		9. AGE (In years lost birthday) 68 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own housework	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Antonio Ruffo (D)		14. MOTHER'S MAIDEN NAME Rosaria Ruffo.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter - Virginian & Pt.'s chart.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Hypertension , (c) Diabetes , (d) Obstruction of arteries of lower extremities			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that death occurred at _____ 6:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE B. M. Schindler, M.D.		22b. DATE SIGNED 20 May 1960	
22c. PHYSICIAN'S NAME (Type) B. M. Schindler, M.D.		22d. ADDRESS 13 Green St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-14-60	
23c. NAME OF CEMETERY OR CREMATORIAL St. Michael's Cemetery		23d. LOCATION (City, town, or county) Frostburg, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Stewart		ADDRESS Frostburg, Md.	
25a. REC'D BY REGISTRAR DATE MAY 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

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20.10.1944
HAMBURG STADTRECHTSBLATT

193



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5244 MEDICAL EXAMINER'S CERTIFICATE OF DEATH **05249**
 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 19 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLA		First S	Middle MILLER
Last F		4. DATE OF DEATH Month May	Day 7
5. SEX W		Year 1960	
6. COLOR OR RACE WIDOWED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 11, 1883
8. IMMEDIATE CAUSE (a) Housewife		9. AGE (in years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Flintstone, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Barkman		14. MOTHER'S MAIDEN NAME Dorothy Herbst	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. John Daychak, Cumberland Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease (Acute Failure) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b) Arteriosclerotic XXXXX C V Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture of Left Hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Fell at Home		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at Home	
20c. TIME OF INJURY Month, Day, Year Hour 1:00 p.m. April 18 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED May 7, 1960	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE MAY 11 '60	
		24b. REGISTRAR'S SIGNATURE Charles L. Krause	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5245		Item 8 Film 0264 6-20-60 et		05250	
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 02		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. STREET ADDRESS 221 AVIRETT AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT		First A.	Middle MORGAN	Last MAY	Month 27
4. DATE OF DEATH Sept 25, 1884		Day 1960	Year 75	IF UNDER 1 YEAR Months 75	IF UNDER 24 HRS. Days Hours Min.
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 25, 1884	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman		10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JAMES MORGAN		14. MOTHER'S MAIDEN NAME ELLEN TEMBELTON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Robert Morgan, 221 Avirett Ave. Cumb.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinomatosis, generalized (c) DUE TO Carcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____ and that death occurred at _____, from the causes and on the date stated above.		22a. SIGNATURE DR. S.G. WEISMAN			
22c. PHYSICIAN'S NAME (Type) DR. S.G. WEISMAN		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/30/60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 31, 1960		23c. NAME OF CEMETERY OR CREMATORIAL SS Peter & Paul's	
23d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George,		ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUN 1 '60	
				25b. REGISTRAR'S SIGNATURE Gutting & Sons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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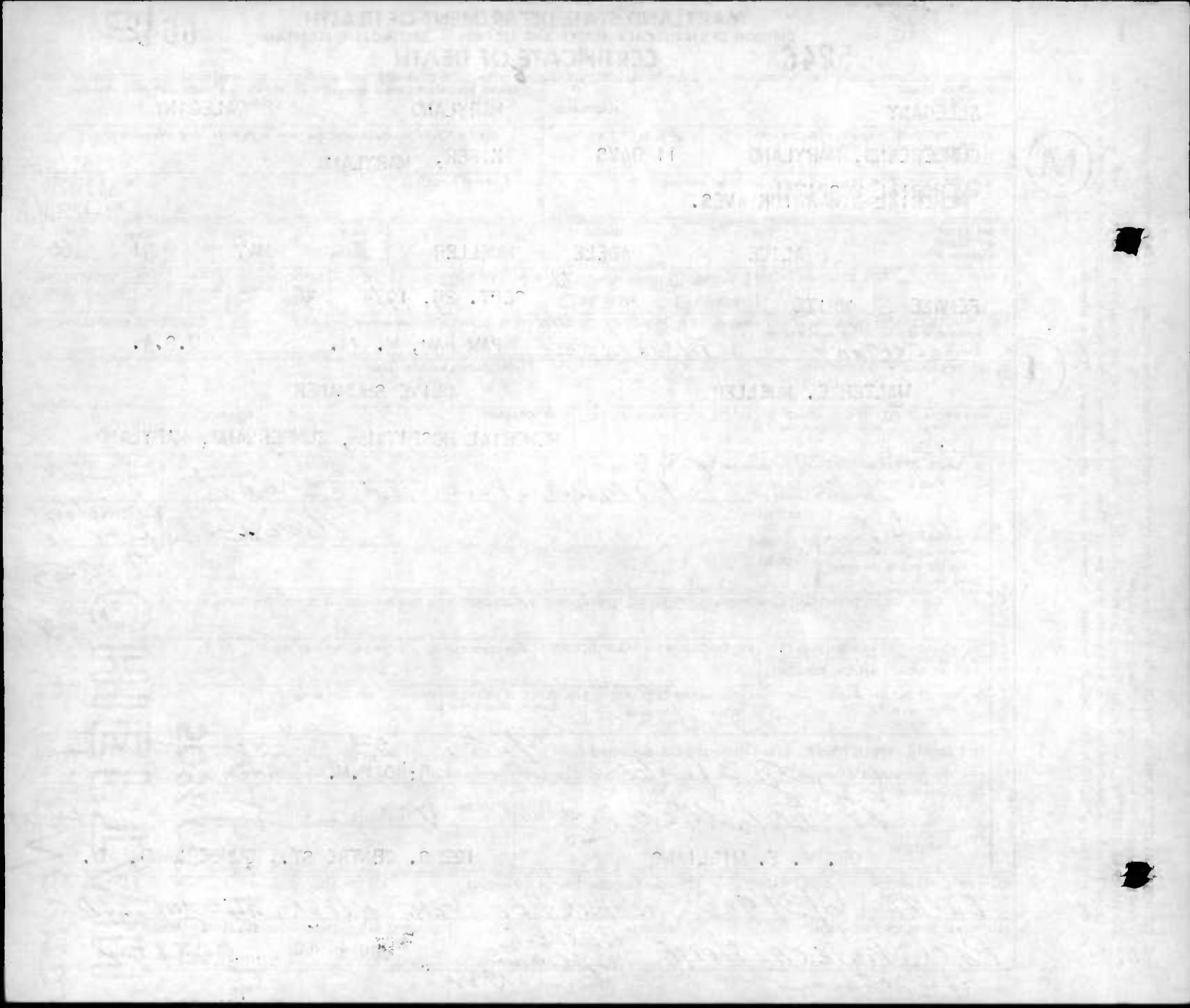
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film 62656 16-60

5246

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		c. LENGTH OF STAY IN lb 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KIFER, MARYLAND		d. STREET ADDRESS 		
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ALICE	Middle ADELE	Last MUELLER	4. DATE OF DEATH MAY 31 1960	Month MAY	Day 31	Year 1960
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1923	9. AGE (In years from birthday) 36	IF UNDER 1 YEAR Months 36	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) PAW PAW, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WALTER E. MUELLER				14. MOTHER'S MAIDEN NAME OLIVE SHUMAKER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		<i>Chronic rheumatic heart disease</i> INTERVAL BETWEEN ONSET AND DEATH Sometime prior to 1953						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>DUE TO</i>						
<i>416X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>DUE TO</i>						
(b)		<i>DUE TO</i>						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9:00 a.m. 1960 to 5:30 p.m. 31 May 1960 , that (I) (we) last saw the deceased alive on 5:30 p.m. 31 May 1960 and that death occurred at 5:40 P.M. the causes and on the date stated above.								
22a. SIGNATURE <i>W. F. Williams</i>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/1/60				
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/3/1960		23c. NAME OF CEMETERY OR CREMATORIAL SULPHUR SPRGS. CEM.		23d. LOCATION (City, town, or county) (State) KIFER, ALLEGANY MD.		
24. FUNERAL DIRECTOR'S SIGNATURE <i>PARKS FUNERAL HOME</i>		ADDRESS BERKELEY SPRINGS, W.VA.		25a. REC'D BY REGISTRAR JUN 8 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH				05251			
1. PLACE OF DEATH a. COUNTY Allegany					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg					c. LENGTH OF STAY IN 1b RURAL					b. COUNTY Maryland							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep					d. STREET ADDRESS /							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First CHARLES	Middle L.	Last MUIR	4. DATE OF DEATH 5/13/1960		Month May	Day 19	Year 19								
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/27/1894		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Shart, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.								
13. FATHER'S NAME Michael Muir					14. MOTHER'S MAIDEN NAME Janet Telford												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-10-2302			17. INFORMANT Mrs. Charles Muir, (WIFE)		Address Nikep, MD.										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH 4 days							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemria DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)										years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Bronchial Asthma : Emphysema : Congestive heart failure										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Act		(County) 1956		(State) to May 13, 1960						
21. I certify that (I) (this hospital) attended the deceased from May 3, 1960 , and that death occurred at 9 AM , from the causes and on the date stated above.																	
22a. SIGNATURE R. Miles, Jr.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 5-14-60							
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., MD					22d. ADDRESS LONACONING MD												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/1960		23c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery			23d. LOCATION (City, town, or county) Moscow, MD.			(State)							
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN					ADDRESS LONACONING, MD.					25a. REC'D BY REGISTRAR DATE MAY 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5247

CERTIFICATE OF DEATH

05252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 740 MARYLAND AVENUE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First MAUDE	Middle THEODOSIA	Last NOLAN	4. DATE OF DEATH	Month MAY	Day 31	Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1887	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Clearsprings, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William H. White				14. MOTHER'S MAIDEN NAME MARY ELLEN HULL		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Hypertensive Cardiac Disease</i> INTERVAL BETWEEN ONSET AND DEATH 443X <i>Vascular Disease</i> <i>for 17 years</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>10-14 1960 to 5-31-1960</i> that (I) (we) last saw the deceased alive on <i>5-30-1960</i> and that death occurred at <i>2:25 AM</i> , from the causes and on the date stated above.								
22a. SIGNATURE <i>W. F. Williams</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5-31-60</i>				
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 2, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, Md.		
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE JUN 6 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5284

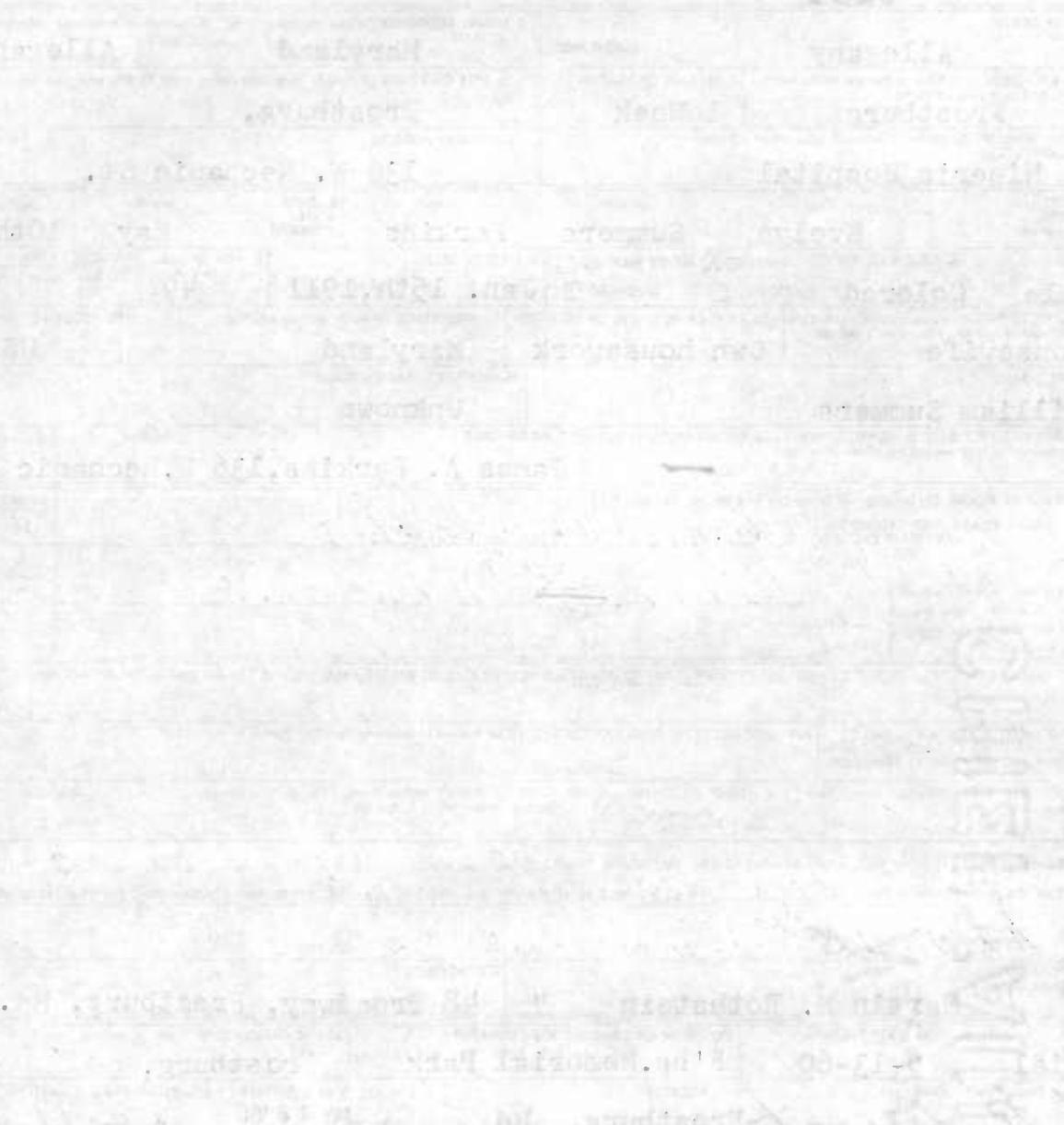
05253

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 Week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Evelyn	Middle Summers	Last Perkins
4. DATE OF DEATH	Month May	Day 10th, 1960	Year
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 15th, 1911
9. AGE (In years lost birthday) 49 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 49 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own housework	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Summers	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. —	17. INFORMANT James A. Perkins, 136 W. Mechanic St. Md.	Address F'bg.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Glomerulonephritis DUE TO Chronic Right Heart Failure INTERVAL BETWEEN ONSET AND DEATH 3 mos ??			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Right Heart Failure (c) 3 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from DEC 22 1959 to 5/10 1960 , that (I) (we) last saw the deceased alive on 5/10 1960 and that death occurred at 116 M , from the causes and on the date stated above.		22b. DATE SIGNED 5/14/60	
22a. SIGNATURE Martin M. Rothstein M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/14/60
22c. PHYSICIAN'S NAME (Type) Martin M. Rothstein		22d. ADDRESS 48 Broadway, Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-13-60	23c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park	23d. LOCATION (City, town, or county) (State) Frostburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		ADDRESS Frostburg, Md.	
		25a. REC'D BY REGISTRAR DATE MAY 16 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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PLATE 30 STANDARD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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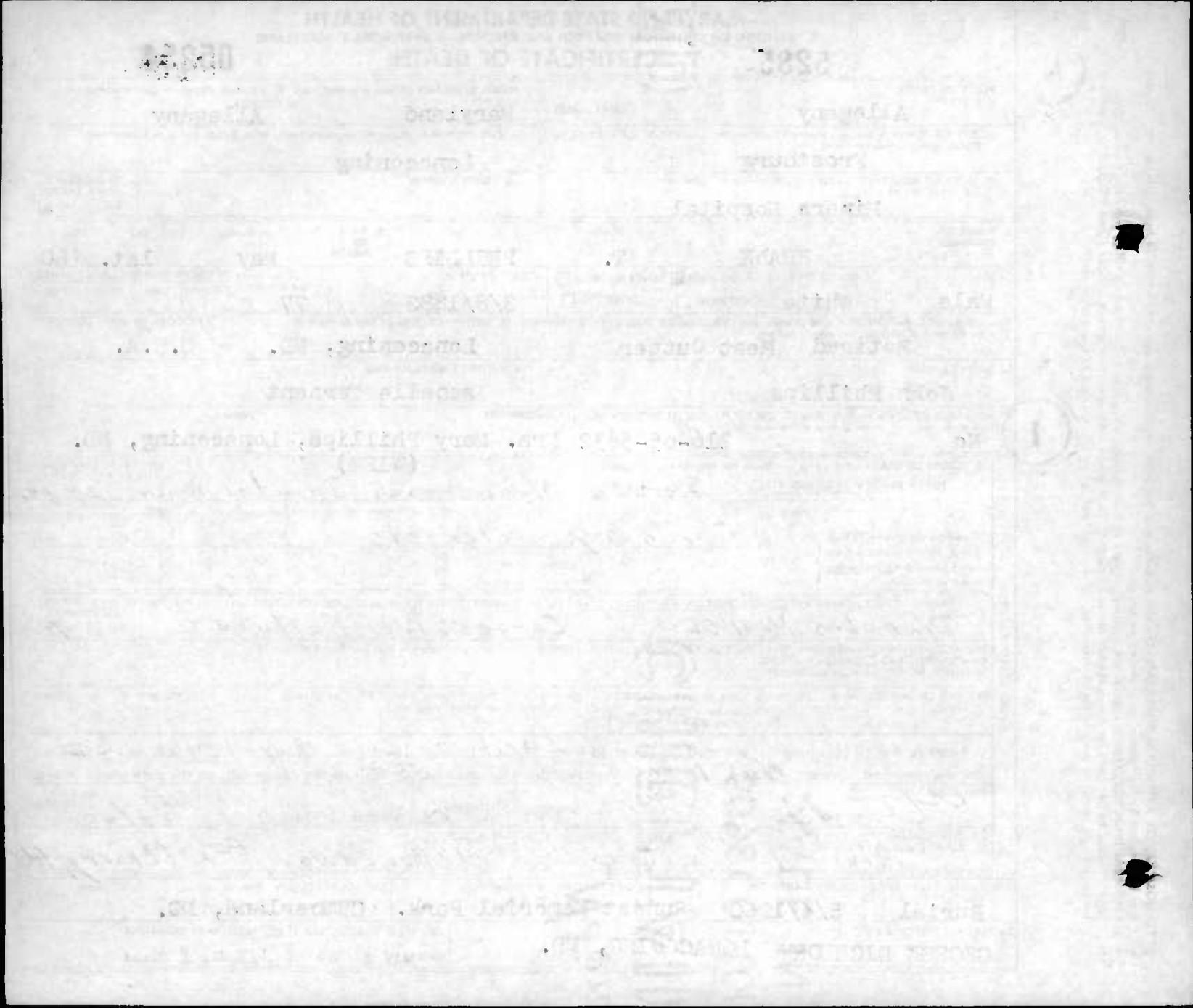
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5285

CERTIFICATE OF DEATH

05254

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRANK	Middle T.	Last PHILLIPS
4. DATE OF DEATH	Month May	Day 1st.	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/8/1883
9. AGE (In years last birthday) 77 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME John Phillips		
14. MOTHER'S MAIDEN NAME Isabelle Ternent		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-05-5832	17. INFORMANT Mrs. Mary Phillips, Lonaconing, MD.	(WIFE)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Coronary Sclerosis.		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus. Congestive Failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 20, 1960 , to May 1, 1960 , that he last saw the deceased alive on April 1, 1960 , and that death occurred at 5:50 AM from the causes and on the date stated above.		22b. DATE SIGNED 5/2/60.	
22a. SIGNATURE Alvin J. Walters.		22d. ADDRESS 48 Broadway, Frostburg, Md.	22b. DATE SIGNED 5/2/60.
22c. PHYSICIAN'S NAME (Type) Alvin J. Walters.	M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/4/1960	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park.	23d. LOCATION (City, town, or county) Cumberland, MD.
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN	ADDRESS LONACONING, MD.	25a. REC'D BY REGISTRAR DATE MAY 4 '60	25b. REGISTRAR'S SIGNATURE Albert S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5248

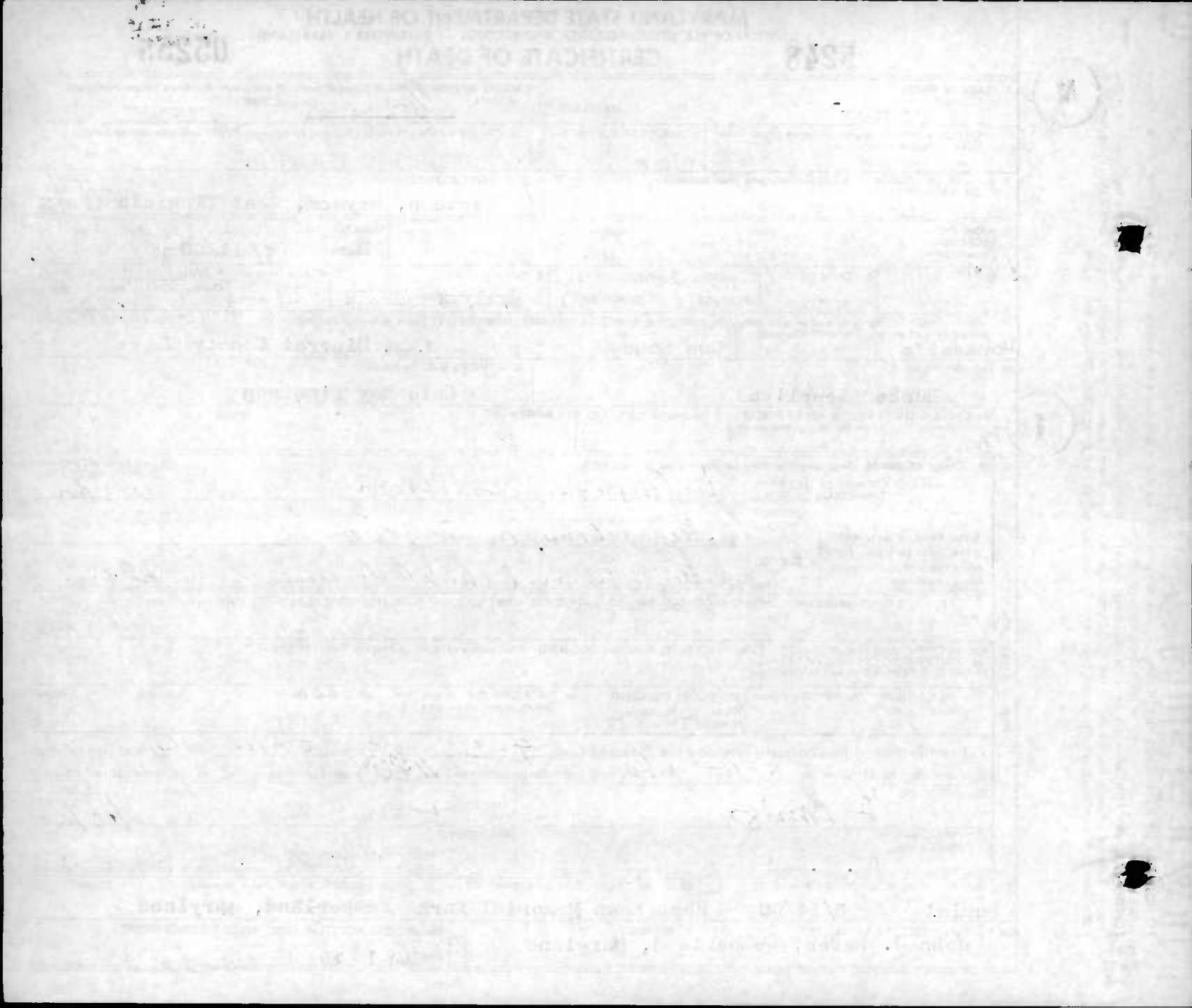
CERTIFICATE OF DEATH

05255

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LILLIAN		First M	Middle PSIMER			
4. DATE OF DEATH 5/11/60		Last 5/11/60	Month May Day 11 Year 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 5/11/60		9. AGE (In years lost birthday) 47 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) W.VA. Mineral County USA			
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bouce Llewellyn				
14. MOTHER'S MAIDEN NAME Lulu May Demison		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. 585		17. INFORMANT CHART	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary embolism DUE TO cholesteroloma on 5-9-60 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) cholesteroloma on 5-9-60 DUE TO cholesterolitis and cholelithiasis 2 years						
INTERVAL BETWEEN ONSET AND DEATH 1/2 hour						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? NO		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m.		20f. (City or town) 57 GREENE STREET	(County) BALTIMORE	(State) MARYLAND
21. I certify that (I) (this hospital) attended the deceased from 4-3 to 5-11 , 19 60 that (I) (we) last saw the deceased alive on 5-11 19 60 , and that death occurred 5-11 19 60 from the causes and on the date stated above.				22b. DATE SIGNED 5/13/60		
22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5/14/60	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Lawn Memorial Park	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				25a. REC'D BY REGISTRAR MAY 17 '60	25b. REGISTRAR'S SIGNATURE John J. Hafer	



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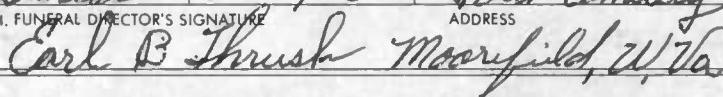
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5249

05255

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD		d. STREET ADDRESS 85X-3			
d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CALVIN		First J.	Middle J.	Last RAINES	4. DATE OF DEATH MAY 27, 1960	Month MAY	Day 27	Year 1960	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 14,		9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME GEORGE RAINES		14. MOTHER'S MAIDEN NAME CATHERINE POWERS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Acute left ventricular failure.		INTERVAL BETWEEN ONSET AND DEATH sudden					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatic surgery for hypertrophic prostatitis and bladder retention.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERNEATH <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/11/60 to 5/27/60 , 19____, that (I) (he) last saw the deceased alive on May 26, 1960 , and that death occurred at 7:50 AM the causes and on the date stated above.									
22a. SIGNATURE 		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 28, 1960			
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON		22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-29-60		23c. NAME OF CEMETERY OR CREMATORIAL Hunt Cemetery		23d. LOCATION (City, town, or county) 6 miles N. Moorefield, Hardy Co., W. Va.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Moorefield, W. Va.		25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause			

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MARYLAND STATE DEPARTMENT OF HEALTH

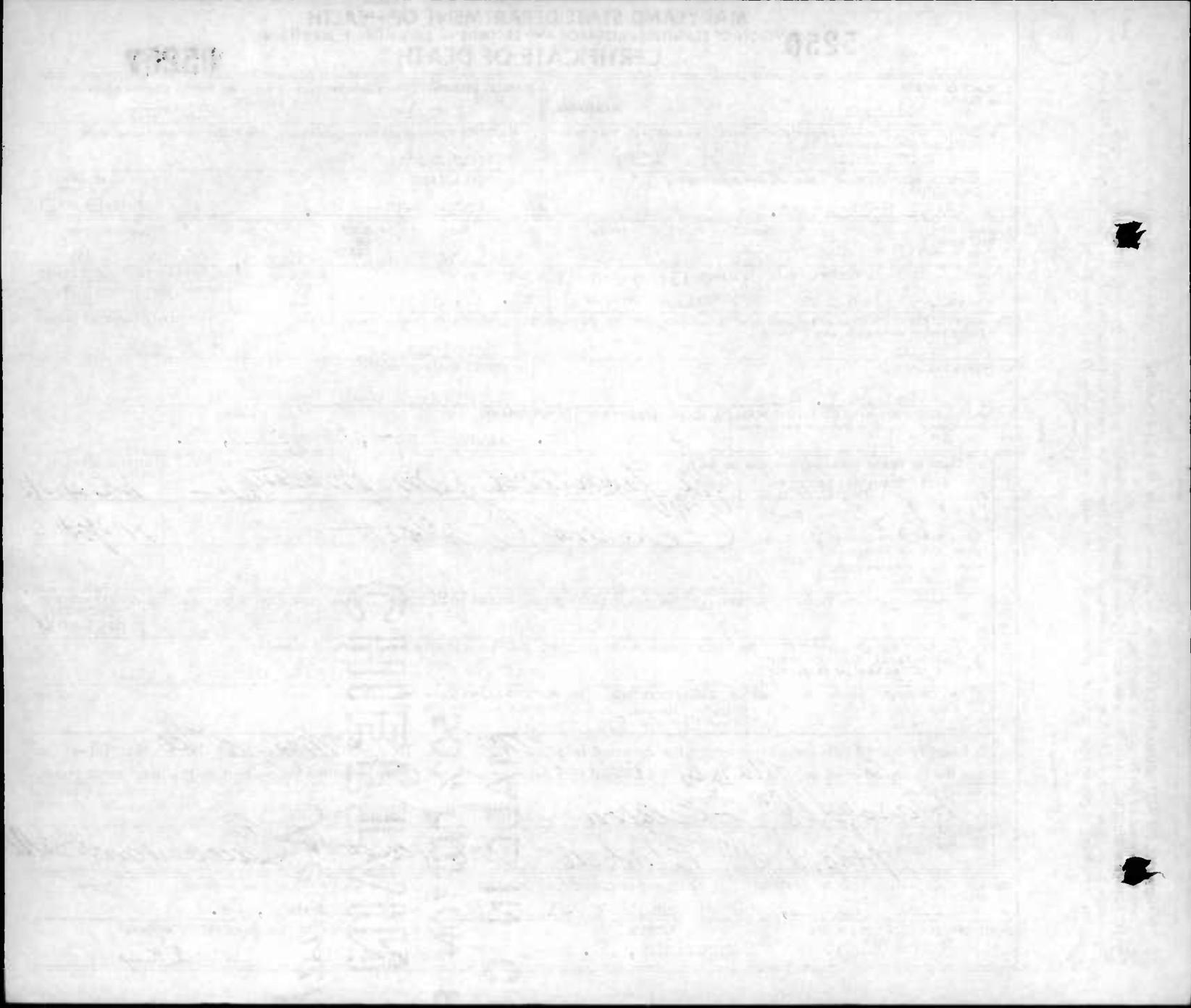
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5250

05257

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1002 Holland St.		e. STREET ADDRESS 1002 Holland St.	
3. NAME OF DECEASED (Type or print) DAVID		First Middle Last RANSOM	4. DATE OF DEATH May 8, 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb. 17, 1949
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Leland B. Ransom		14. MOTHER'S MAIDEN NAME Mildred McMillen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Leland Ransom, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351 DUE TO Asphyxiation (Inspiratory) - Cerebral Edema. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 11 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10 A.M. on May 8, 1960 , that (I) (we) last saw the deceased alive on March 19, 1960 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Harold Wm Ellison		22b. DATE SIGNED 22nd May 1960	
22c. PHYSICIAN'S NAME (Type) Harold Wm Ellison		22d. ADDRESS 126 Avenue 8th Cumberland Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 11, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL PARK Sunset Memorial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
		25a. REC'D BY REGISTRAR DATE MAY 11 '60	
		25b. REGISTRAR'S SIGNATURE Clifford S. Trahan	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

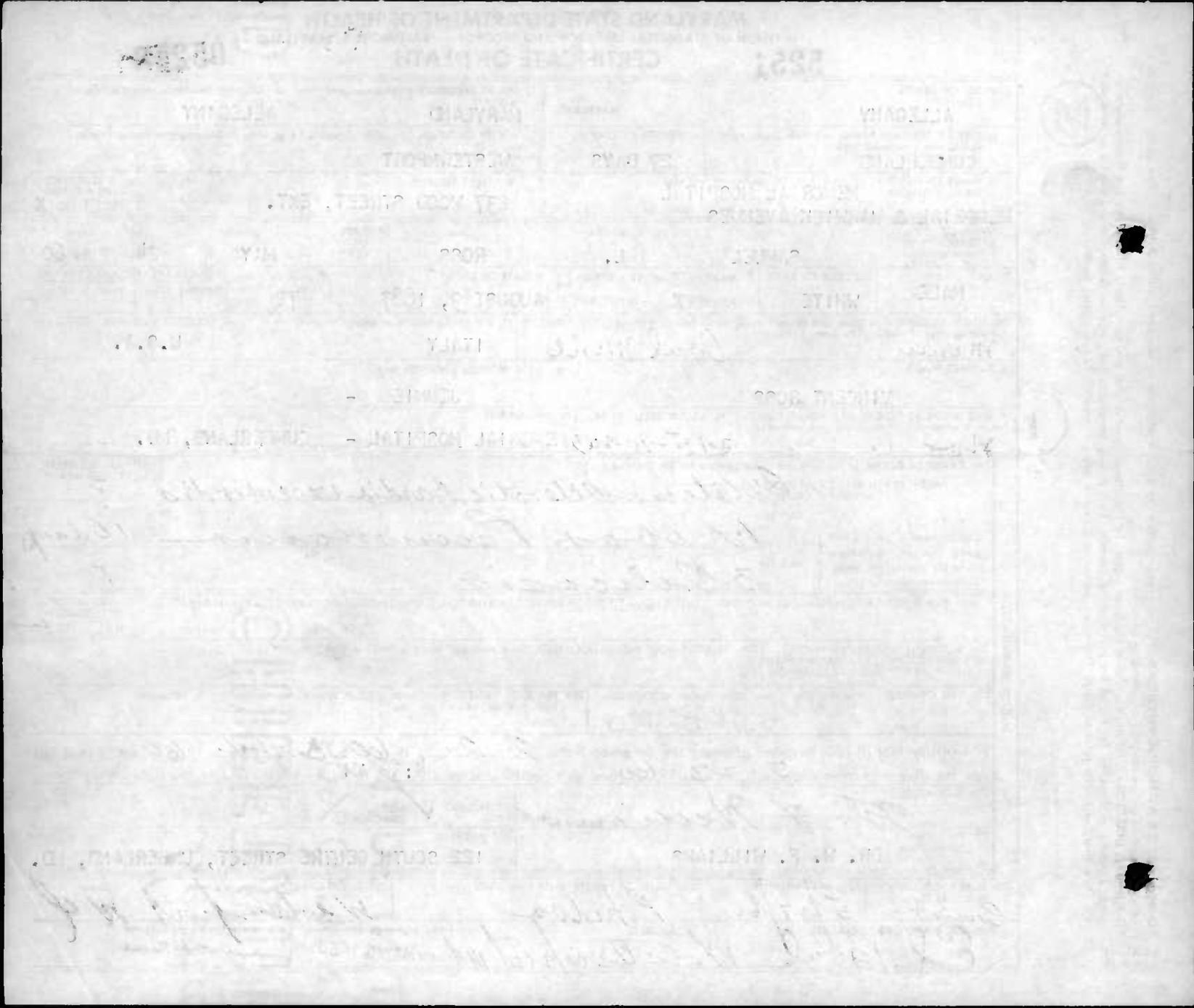
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5251

CERTIFICATE OF DEATH

05258

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 27 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT		d. STREET ADDRESS 237 WOOD STREET, EXT.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle L.	Last ROSS	4. DATE OF DEATH	Month MAY	Day 24	Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 9, 1887		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Civil Mine		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME VINCENT ROSS		14. MOTHER'S MAIDEN NAME JENNIE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-803		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		<i>Arteriosclerotic Cardiovascular Disease</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 490X		DUE TO (b)	<i>Chronic Pneumonia</i> 10 days					
		DUE TO (c)	<i>3. Delirious</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 21. 2. 19 60 to 5. 24. 19 60 that (I) (we) last saw the deceased alive on 5. 23. 19 60 and that death occurred at 4:30 AM from the causes and on the date stated above.								22b. DATE SIGNED
22a. SIGNATURE <i>Dr. W. F. Williams</i>		ATTENDING MED. PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 SOUTH CENTRE STREET, CUMBERLAND, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/7/60		23c. NAME OF CEMETERY OR CREMATORIAL Phelps		23d. LOCATION (City, town, or county) Westernport W.F.		(State)
24. FUNERAL DIRECTOR'S SIGNATURE <i>Ed. Boul - Westernport, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5252

CERTIFICATE OF DEATH

05259

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 18 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 208 MARYLAND AVE.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First ROBERT	Middle WAYNE	Last ROUCH, JR.	4. DATE OF DEATH MAY 12 1960	Month MAY	Day 12	Year 1960		
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 3, 1960		9. AGE (In years last birthday) yrs. 4 9	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS. Days 9	Hours one hour	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME ROBERT WAYNE ROUCH, SR.				14. MOTHER'S MAIDEN NAME JANICE BROWN						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>570.0</i> , probably, nervous in origin, one hour								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Post-operative adhesions of the intestine. (Operated on for intussusception)								
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) April 24 1960		(County) May 12 1960		(State)
21. I certify that (I) (this hospital) attended the deceased from April 24 1960 to May 12 1960 , that (I) (we) last saw the deceased alive on May 12 1960 , and that death occurred at 8:25 AM from the causes and on the date stated above.										
22a. SIGNATURE <i>A. Hashim</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/13/60		
22c. PHYSICIAN'S NAME (Type) DR. HASHIM		22d. ADDRESS 20 GREENE ST., CUMBERLAND, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/15/60		23c. NAME OF CEMETERY OR CREMATORIAL Temple Cemetery		23d. LOCATION (City, town, or county) (State) Near Wellersburg, Pa.				
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR MAY 19 '60		25b. REGISTRAR'S SIGNATURE <i>Carling S. Turner</i>				

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THERMOPHILIC BACTERIA

2.11. *Yucca whipplei* T. & G.

O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the patient has died by the hospital or attending physician.

O FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5253

CERTIFICATE OF DEATH

05260

1. PLACE OF DEATH a. COUNTY ALLEGANY			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA.			b. COUNTY MINERAL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			c. LENGTH OF STAY IN 1b 16 HRS. 17 MINS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD, W. VA.			d. STREET ADDRESS 85 X-3				
d. NAME OF HOSPITAL (If outside corporate limits, give street address) MEMORIAL & WARWICK AVE.								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First BABY BOY		Middle	Last SACHS	4. DATE OF DEATH	Month MAY	Day 14	Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1960		9. AGE (In years lost birthday) yrs. 16		IF UNDER 1 YEAR Months 16 Dofs 17		IF UNDER 24 HRS. Hours 16 Minutes 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME HARVEY DENVER SACHS			14. MOTHER'S MAIDEN NAME MARION TAYLOR									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Operatively			DUE TO Placenta Praevia - Complete						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO P			(b)									
DUE TO c												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) May 13		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 17 1960 to May 14 1960 , that (I) (we) last saw the deceased alive on May 17 1960 , and that death occurred at 2:07 P.M. the causes and on the date stated above.						May 13 to May 14 , 1960, at 2:07 P.M.			22b. DATE SIGNED			
22a. SIGNATURE W R Royce Hodges			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) DR. HODGES & MOULD			22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-16-60		23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park			23d. LOCATION (City, town, or county) Cumberland, Md.			(State)		
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE MAY 19 '60			25b. REGISTRAR'S SIGNATURE Charles S. Trahan			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND															
5254				CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. LENGTH OF STAY IN 1b 24 DAYS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.							
d. NAME OF HOSPITAL (If institutional, give street address) MEMORIAL & WARWICK AVE.				e. STREET ADDRESS 18 ELDER STREET				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First CATHERINE		Middle D.		Last SHARON		4. DATE OF DEATH		Month	Day	Year			
S. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-18-1915		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Previous-Textile				11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSEPH BEARINGER						14. MOTHER'S MAIDEN NAME MYRTLE DORBIN									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT						Address 217-10-710 MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rheumatic Cvd.</i> — <i>Cerebral</i> — <i>Stroke</i> 416X DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberg. Alley 101				20f. (City or town) <i>Cumberg. Alley 101</i> (County) <i>Allegany Co</i> (State) <i>Md.</i>			
21. I certify that (I) (this hospital) attended the deceased from 7/4/60 , 19, to 5/2/60 , 19, that (I) (we) last saw the deceased alive on 7/4/60 , 19, and that death occurred at 9:20 P.M. from the causes and on the date stated above.															
22a. SIGNATURE <i>R.J. Williams</i>												22b. DATE SIGNED May 19 60			
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS				22d. ADDRESS 122 SOUTH CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-15-60		23c. NAME OF CEMETERY OR CREMATORIAL St. Mary's cem.				23d. LOCATION (City, town, or county) Cumberland, Md.				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.												ADDRESS James F. Scarpelli Cumberland, Md.			
												25a. REC'D BY REGISTRAR DATE MAY 19 60		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
52 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05262
 Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 25 min.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural #1	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma		First Mag Middle Shipley Last	
4. DATE OF DEATH May 23,		Month	Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 29, 1883
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houswife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James K. Hickie		14. MOTHER'S MAIDEN NAME Susan Barnds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none	
17. INFORMANT Daughter: Mrs. Beatrice Johnston		Address P.T. #1, Cumberland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20g. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic MD.		DATE SIGNED 5/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/60	
22c. NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland. Md.	
24a. REC'D BY REGISTRAR DATE MAY 27 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Kline</i>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the burial permit. File Pages 1 and 2 with the State Board of Health.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05263

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 51		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. STREET ADDRESS 513 Maryland Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 22 miles east of Cumberland Allegany, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William		First Dennis	Middle Shook	Lost	4. DATE OF DEATH May 3 1960	Month May	Day 3	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec 16, 1918	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY 71 cab		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME William Shook				14. MOTHER'S MAIDEN NAME Illie May Groves				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Not, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 212-12-8762		17. INFORMANT Mrs. Martha Shook		513 Maryland Avenue. Cumberland, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull INTERVAL BETWEEN ONSET AND DEATH Sudden 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Automobile Accident DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Also fractures and burns of lower extremities 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto crashed into tree						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11:00 p. m. 5/3 1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) route 51		20f. (City or town) 22 miles east of (County) Cumberland Allegany (Md.) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		DATE SIGNED 5/4/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/5/60		22c. NAME OF CEMETERY OR CREMATORIUM Sunset Memorial Park		22d. LOCATION (City, town, or county) Cumberland Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR MAY 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5290

05264

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport							
c. LENGTH OF STAY IN lb 70 Yrs				d. STREET ADDRESS 74 Main							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 74 Main				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Mary	Middle Elizabeth	Last Shultice	4. DATE OF DEATH May 4 1960	Month May	Day 4	Year 1960			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 20, 1871			9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME James Morrison				14. MOTHER'S MAIDEN NAME Esther R. Clark				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. A.B. Kalbaugh - Westernport, Md.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema								INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO Left Ventricular Failure								3 days			
(c) DUE TO Acute Myocardial Infarction								3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
July 1 1959		19									
21. I certify that (I) (this hospital) attended the deceased from July 1 1959 to April 4 1960 , that (I) (we) last saw the deceased alive on April 3 1960 , and that death occurred at 8:15 A.M. from the causes and on the date stated above.											
22d. SIGNATURE Robert W. Bess, Jr., M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1960			
22e. PHYSICIAN'S NAME (Type) Robert W. Bess, Jr., M.D.				22d. ADDRESS Piedmont, W. Va.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/6/60		23c. NAME OF CEMETERY OR CREMATORIAL Philos		23d. LOCATION (City, town, or county) Westernport		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE E. Boral				ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR DATE MAY 6 '60		25b. REGISTRAR'S SIGNATURE Cirius S. Trahan	

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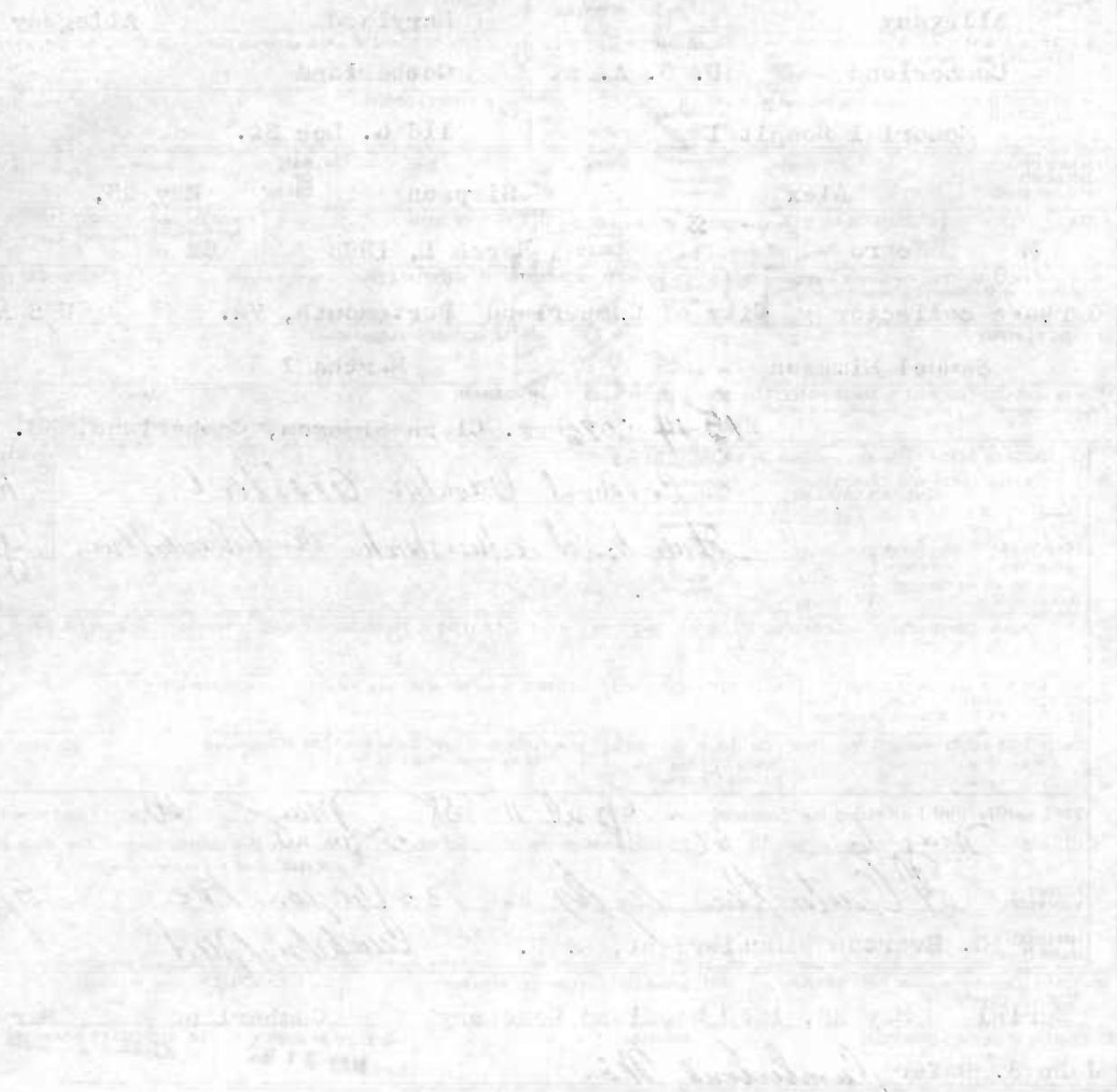
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 05265	
5256 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland D. O. A. at					c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital					d. STREET ADDRESS 116 S. Lee St.						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Alex		First	Middle	Last	4. DATE OF DEATH May 25,		Month	Day	Year		
5. SEX M Negro		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1898		9. AGE (In years last birthday) 62 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garbage collector		10b. KIND OF BUSINESS OR INDUSTRY City of Cumberland		11. BIRTHPLACE (State or foreign country) Portsmouth, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Samuel Simpson					14. MOTHER'S MAIDEN NAME Martha ?						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 215-14-6084		INFORMANT Mrs. Clara Simpson, Cumberland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH hrs						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					Cerebral Vascular Accident						
(b) DUE TO					Gastrointestinal hemorrhage						
(c) DUE TO					Years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 133 Lee Street		20f. (City or town) (County) (State) Cumberland, Md.		
21. I certify that I attended the deceased from April 11, 1958, to May 6, 1960, that I last saw the deceased alive on May 6, 1960, and that death occurred at 2:00 P.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 5/26/60	
ACTUAL SIGNATURE G. Overton Himmelwright, M. D.											
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 28, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Cumberland					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Md.											
24a. REC'D BY REGISTRAR DATE MAY 31 '60					24b. REGISTRAR'S SIGNATURE						

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X MT. SAVAGE		d. STREET ADDRESS /					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ELIZABETH E.		First	Middle	Last	4. DATE OF DEATH SKIPPER	Month MAY	Doy 16	Year 1960			
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 7, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Six Mile Run, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HARTMAN O'NEAL				14. MOTHER'S MAIDEN NAME ESTHER WILLIAMS							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO 420.1						INTERVAL BETWEEN ONSET AND DEATH 4 DAYS					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO CORONARY ARTERY DISEASE (c)				4 TO 5 YEARS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 5-13-60		(County) 19		(State) 5-16-60	
21. I certify that (I) (this hospital) attended the deceased from 5-13-60 19 to 5-16-60 19, that (I) (we) last saw the deceased alive on 5-15-60 19, and that death occurred at 2:20 AM the causes and on the date stated above.											
22a. SIGNATURE William P. James		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 220 AM	
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES		22d. ADDRESS 441 NORTH CENTRE ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-18-60		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Methodist Cemetery Hafer Funeral Home		23d. LOCATION (City, town, or county) Mt. Savage		(State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Reuben H. McIntosh		ADDRESS 23 E. Main, Frostburg, Md.		25a. REC'D BY REGISTRAR JAY 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Krause					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5258

CERTIFICATE OF DEATH

05267

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 4/29/53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Effie	Middle Smith	4. DATE OF DEATH Month May Day 22, 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Cash Clerk - Dept. Store		10b. KIND OF BUSINESS OR INDUSTRY Rosenbaum's	11. BIRTHPLACE (State or foreign country) Frostburg, Maryland
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Anne Faraday	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (if yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT P.O. Box 599 Allegany County Infirmary Records Address Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Chronic Myocardial Degeneration INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral Hemorrhage ? (c) DUE TO Cerebral arteriosclerosis ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Deterioration .			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 4/29/53 , 19, to 5/22/60 , 19, that (I) (we) last saw the deceased alive on 5/23/60 , 19, and that death occurred at 1:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>James E. McLean</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 25/5/60
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean	22d. ADDRESS 49 Greene St., Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-24-60	23c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park	23d. LOCATION (City, town, or county) (State) Frostburg, Md.
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. P. Frost</i>		ADDRESS Frostburg, Md.	25a. REC'D BY REGISTRAR DATE MAY 25 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5259

CERTIFICATE OF DEATH

05268

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8½ HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELIZABETH	Middle M.	Last SMITH
4. DATE OF DEATH	Month MAY	Day 29,	Year 19 60.
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 30, 1911
9. AGE (In years last birthday) 48 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME HARRY W. MATHENEY		
14. MOTHER'S MAIDEN NAME GERTRUDE SINCELL	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with left hemiplegia DUE TO 33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 13 hours.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6 A.M. to 1 P.M. 29 May 1960 that (I) (we) last saw the deceased alive on 29 May 1960 , and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. Alfred Van Ormer		22b. DATE SIGNED 29 May 60	
22c. PHYSICIAN'S NAME (Type) DR. W. ALFRED VAN ORMER		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 1, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	23d. LOCATION (City, town, or county) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		ADDRESS	
		25a. REC'D BY REGISTRAR DATE JUN 3 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Trahan

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5260

CERTIFICATE OF DEATH

05269

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 53 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		d. STREET ADDRESS 406 LOUISIANA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL													
3. NAME OF DECEASED (Type or print) SMITH, KATE ELIZABETH		First Middle Last		4. DATE OF DEATH 5-8-60		Month Day Year							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-1877		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARTINSBURG, W. VA.		12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME LOUIS WELLIN		14. MOTHER'S MAIDEN NAME MARGARET LOUISE CREIG											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												<i>Carcinomatous</i>	
170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b)		<i>Carcinoma of Both Breasts</i>		DUE TO (c)						<i>days</i>	
		DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from June 1956 to May 8, 1960 , that (I) (we) last saw the deceased alive on May 7, 1960 and that death occurred at 7:03 AM , from the causes and on the date stated above.													
22a. SIGNATURE <i>Clay E. Durrett</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5/9/60							
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 W. 4th Cumberland rd.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/60		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) Cumberland, Maryland		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DA 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline							

0082
CHARLES TECHEY'S
STAGE CO STATION

0082

THEATER
ONLY YOU

THE DRUGS

SKIN

THE MARCH

THE CROWN

HYDROXYLIC FISHES

LINE

THE WIND

DAY OF GRASS IN THE

BLUES 20104 TETRIS

KILLER

THE CHASES, LITTLE JAHNS

THREE, 2 YARD

THE CHASES, LITTLE JAHNS

THE CHASES, LITTLE JAHNS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05270
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 38 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 21 Pennsylvania Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
f. STREET ADDRESS 21 Pennsylvania Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ellis		First T.	Middle Sneathen
Last 		4. DATE OF DEATH May 31, 1960	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Builder	
11. BIRTHPLACE (State or foreign country) Fort Ashby W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Sneathen		14. MOTHER'S MAIDEN NAME Sally Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 214-05-6107	
17. INFORMANT Address Mrs. Hilda Sneathen, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot Wound Of Head		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 976X (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Self Inflicted		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self Inflicted	
20c. TIME OF INJURY Month, Day, Year Hour 5:00 a.m. 5-31 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) Cumberland		(County) Allegany	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Benedict Skitarelic		DATE SIGNED May 31, 1960	
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 3, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JUN 3 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Traas	

DEPARTMENT OF HEALTH - DIVISION OF MEDICAL EXAMINER - CERTIFICATE OF DEATH

REGISTRATION NO.

NAME OF DECEASED

NAME OF MEDI

ADDRESS OF MEDI

ADDRESS OF MEDI

NAME OF DOCTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										05271
5286					CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 3 days. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lonaconing, MD. d. STREET ADDRESS Detmold Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First MARGARET	Middle	Last SNYDER	4. DATE OF DEATH	Month 5/16/1960	Day	Year 19		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5/12/1981	9. AGE (In years last birthday) 79 <input checked="" type="checkbox"/> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Lonaconing, MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Beeman					14. MOTHER'S MAIDEN NAME Sarah C. McCloud					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Lindley Snyder		Address Lonaconing, MD. (SON)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH 12 hours
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO myocardial dilatation acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO arteriosclerosis (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Oct. 1956 to May 16, 1960, that (I) (we) last saw the deceased alive on May 16, 1960, and that death occurred at 6 PM, from the causes and on the date stated above.										22b. DATE SIGNED
22a. SIGNATURE <i>L. R. Miles Jr., M.D.</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) L. R. MILES JR., M.D.					22d. ADDRESS LONACONING MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/19/1960		23c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery			23d. LOCATION (City, town, or county) (State) Lonaconing, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN					ADDRESS LONACONING, MD.					
					25a. MAY 19 1960 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

Учебник
математики
для 1-го класса
авторов А.Г.Макарычева,
М.И.Макарычевой
и Г.В.Дорофеева
издательства
«Просвещение»
Москва
1987 год
Учебник
математики
для 1-го класса
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М.И.Макарычевой
и Г.В.Дорофеева
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Москва
1987 год

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												05272					
5262				CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 DAYS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CUMBERLAND (RURAL)									
d. NATURE OF HOSPITAL (If hospital, give street address) ORGANIZATIONAL HOSPITAL MEMORIAL & WARWICK AVES.								d. STREET ADDRESS / ROUTE 2, WILLIAMS ROAD									
3. NAME OF DECEASED (Type or print) First EPHRIAM Middle Last STAFFORD				4. DATE OF DEATH MAY 25 1960				Month		Day		Year					
S. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		NOV. 25, 1889		70 yrs.		Months		Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
Farmer				Farming				WEST VIRGINIA				U.S.A.					
13. FATHER'S NAME GEORGE STAFFORD												14. MOTHER'S MAIDEN NAME MARTHA BUCY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.				17. INFORMANT				Address					
				216-04-3011				MEMORIAL HOSPITAL				CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary occlusion												15 mos.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.												DUE TO (b) Arteriosclerotic Heart disease DUE TO (c) Generalized Arterosclerosis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 17, 1960, to May 25, 1960, that (I) (we) last saw the deceased alive on May 25, 1960, and that death occurred at 9:30PM, from the causes and on the date stated above.																	
22a. SIGNATURE DR. GEORGE SIMONS												22b. DATE SIGNED 5/27/60					
22c. PHYSICIAN'S NAME (Type)				M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.				MED. DIRECTOR <input type="checkbox"/>				STAFF PHYS. <input type="checkbox"/>					
								22d. ADDRESS				ALGONQUIN HOTEL, CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 28, 1960				23c. NAME OF CEMETERY OR CREMATORIAL Mt. Herman Cemetery				23d. LOCATION (City, town, or county) Cumberland, Md. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.												ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 '60		25b. REGISTRAR'S SIGNATURE Arthur J. Thrall	

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1968-1970

2007

1. *Leucosia* (L.) *leucostoma* (L.)

ANSWER

1996-1997 学年第二学期期中考试

2010-2020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5263

CERTIFICATE OF DEATH

05273

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/2/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Orpha	First B.	Middle B.	Last Tabler
4. DATE OF DEATH 10/10/1882	Month May	Day 31	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1882
9. AGE (In years lost birthday) 77	10. IF UNDER 1 YEAR Months 77	11. IF UNDER 24 HRS. Days 0	12. CITIZEN OF WHAT COUNTRY? Greenville Twnshp U. S. A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Christian Engle	14. MOTHER'S MAIDEN NAME Emma Boucher		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT P.O.Box 599 Allegany County Infirmary Records	Address Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
422.2 DUE TO Pulmonary Hypostasis 75 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis ?			
DUE TO (c) Osteo-arthritis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis, & psychosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/2/58 , 19, to 5/31/60 , 19, that (I) (we) last saw the deceased alive on 5/31/60 , 19, and that death occurred at 7:35 P.M. from the causes and on the date stated above.			
22o. SIGNATURE James E. McLean		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 6/1/60
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean	22d. ADDRESS 49 Greene St., Cumberland, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/3/60	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Mausoleum	23d. LOCATION (City, town, or county) (State) Cumberland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE JUN 3 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Kline

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5264

CERTIFICATE OF DEATH

05274

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 23 DAYS		
d. NAME OF HOSPITAL (if not known, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First HOY	Middle (Roy)	Last THOMPSON	
4. DATE OF DEATH	Month MAY	Day 9	Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1892	
9. AGE (In years lost birthday) 67	10. IF UNDER 1 YEAR Months 67	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13. FATHER'S NAME WEST THOMPSON	14. MOTHER'S MAIDEN NAME Susan Clayton	15. CITIZEN OF WHAT COUNTRY? U.S.A.		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes	17. SOCIAL SECURITY NO. 214-16-2584	18. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH 3 week		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO				
(c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from _____ 19 _____. to _____ 5/9 _____. 19 ____, that (I) (we) last saw the deceased alive on _____ 5/9 _____. 19 ____, and that death occurred at 3:25 P.M. the causes and on the date stated above.				
22o. SIGNATURE <i>R. Weisman</i>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) DR. WEISMAN		22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 12, 1960		23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park
23d. LOCATION (City, town, or county) Cumberland, Maryland		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		25a. REC'D BY REGISTRAR DATE MAY 16 '60		
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Trahan		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5265

CERTIFICATE OF DEATH

05275

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/18/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First John	Middle Henry	Last Twigg
4. DATE OF DEATH May 25, 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/1880
9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Tin Mill Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Israel Twigg		14. MOTHER'S MAIDEN NAME Nancy N. Twigg (Maiden Name was Twigg)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 260X		16. SOCIAL SECURITY NO. P.O.Box 599	
17. INFORMANT Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myoskeletal Degeneration, INTERVAL BETWEEN ONSET AND DEATH 260X DUE TO ?			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis. ? DUE TO ? (c) Diabetes Mellitus. ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Respiritis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/18/58 19 to 5/25/60 19, that (I) (we) last saw the deceased alive on 5/24/60 19, and that death occurred at 10:35 A.M. on the above dates and on the date stated above.			
22a. SIGNATURE <i>James E. McLean</i>		22b. DATE SIGNED 5/25/60	
22c. PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. ADDRESS 49 Greene Street Cumberland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 28, 1960	
23c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE MAY 31 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05276

5266			
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Disp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale,	
3. NAME OF DECEASED (Type or print) Maude Irene		d. STREET ADDRESS 1064 Cedar St.,	
First Maude		Middle Irene	Last Twigg
4. DATE OF DEATH 5/6/60		Month May	Day 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 3, 1889		9. AGE (In years last birthday) 71	IF UNDER 1 YEAR Yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Elk Garden, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Edward Bailey		14. MOTHER'S MAIDEN NAME Jeannette Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Glenn Twigg, LaVale, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1		INTERVAL BETWEEN ONSET AND DEATH sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Auricular fibrillation	
{		1 yr. plus	
DUE TO (c)		coronary arteriosclerosis	
{		?	
Myocardial fibrosis, lt. ventricular hypertrophy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (his Hospital) attended the deceased from May 2 1960, and that death occurred at 10:15 P.M. on the causes and on the date stated above.		12/ 19 58 to May 6 19 60	
22a. SIGNATURE Dr. S.M. Jacobson		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/9/60
22c. PHYSICIAN'S NAME (Type) Dr. S.M. Jacobson		22d. ADDRESS 50 Pershing St. Cumberland, Md.	
23a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		23b. DATE THEREOF May 9, 1960	23c. NAME OF CEMETERY OR CREMATORIAL Sunset Memorial Park
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		23d. LOCATION (City, town, or county) Cumberland, Md.	
ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 10 '60	
25b. REGISTRAR'S SIGNATURE Charles L. George			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
526 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05277

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

M

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 1500 Virginia Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First RICHARD	Middle MALIN	Last TWIGG	4. DATE OF DEATH May 20	Month May	Day 20	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 6, 1892	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brkmn				10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad			
11. BIRTHPLACE (State or foreign country) Orleans Crossroads, W.Va.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Harmon Twigg				14. MOTHER'S MAIDEN NAME Mollie Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 705-07-9505 17. INFORMANT Mrs. Sarah L. Twigg			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to Coronary Occlusion				Address 1500 Va. Ave. Cumberland, Maryland			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Due to Coronary Sclerosis				INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				DATE SIGNED May 21, 1960			
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 24, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR MAY 24 '60			
				24b. REGISTRAR'S SIGNATURE <i>Clifford S. Kraus</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05278**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 13 hours	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERALDINE L.		First GERALDINE	Middle L.
Last VALENTINE		4. DATE OF DEATH MAY 29	Month Day Year 1960
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 27 1941
			9. AGE (In years from birthday) 18 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWN HOME HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) Bath, New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CARL STINSON		14. MOTHER'S MAIDEN NAME ISABEL HAYES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Frank R. Valentine, Cumberland, Md.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 3-5 Hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 672 X			
(b) CONGENITAL VASCULAR ANOMALY		----	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (DIED 20 MINUTES POSTPARTUM)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED Benedict Skitarelic	
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MAY 29, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 1, 1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR JUN 3 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

DEPARTMENT OF DEFENSE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05279

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 28 Schiller Terrace		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D. O. A. Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harley C. Wagoner		First	Middle	Last	4. DATE OF DEATH May 22 1960	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 10, 1880	9. AGE (In years lost birthday) 80 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Colanese Corp. of America		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles Wagoner		14. MOTHER'S MAIDEN NAME Mary Shryock						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-1929		17. INFORMANT Sadie L. Wagoner 28 Shiller Terrace, Cumb. Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		DUE TO 442		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Final disease (obtuse)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 122 S. Centre Street	(County)	(State)	
21. I certify that I attended the deceased from 5-10 , 19 60 , to May 22 , 19 60 , that I last saw the deceased alive on 5-15-1960 , and that death occurred at 6P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Richard J. Williams, M.D. 122 S. Centre Street DATE SIGNED 5/24/60								
ACTUAL SIGNATURE Richard J. Williams, M.D.		PHYSICIAN'S NAME (Type)		Cumberland, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/25/60	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rose Hill Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.	23b. ADDRESS 117 Frederick St. Cumb. Md.	24a. REC'D BY REGISTRAR MAY 26 '60	24b. REGISTRAR'S SIGNATURE Robert S. Kraus					

WAGUARD STATE DEPARTMENT OF HEIN-SATLIMORE, JR

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5270

CERTIFICATE OF DEATH

05280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>829 Buckingham Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>	
3. NAME OF DECEASED (Type or print) <u>William H. Walker</u>		d. STREET ADDRESS <u>829 Buckingham Rd</u>	
4. DATE OF DEATH <u>May 24</u>	Month <u>May</u>	Day <u>24</u>	Year <u>1960</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>May 30, 1893</u>
8. AGE (In years last birthday) <u>66</u>	9. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	10. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec & Treasurer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Springfield Inc Co</u>	
10c. BIRTHPLACE (State or foreign country) <u>Chicago Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Walker</u>		14. MOTHER'S MAIDEN NAME <u>Clara Chalfont</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>261-01-0849</u>	
17. INFORMANT <u>Mrs. Wm. H. Walker</u>		Address <u>Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Tissue</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <u>Carcinoma of rectum</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>60</u> , to <u>May 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 21</u> , 19 <u>60</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>M.D. 122 S. Center St. Cumberland, Md</u>			
DATE SIGNED <u>5-26-60</u>			
ACTUAL SIGNATURE <u>D. Morris</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nanakor</u>		22b. DATE THEREOF <u>5/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Beinhauer Cemetery Pittsburgh Pa</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u>		ADDRESS <u>Cumb. Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAY 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Mann</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

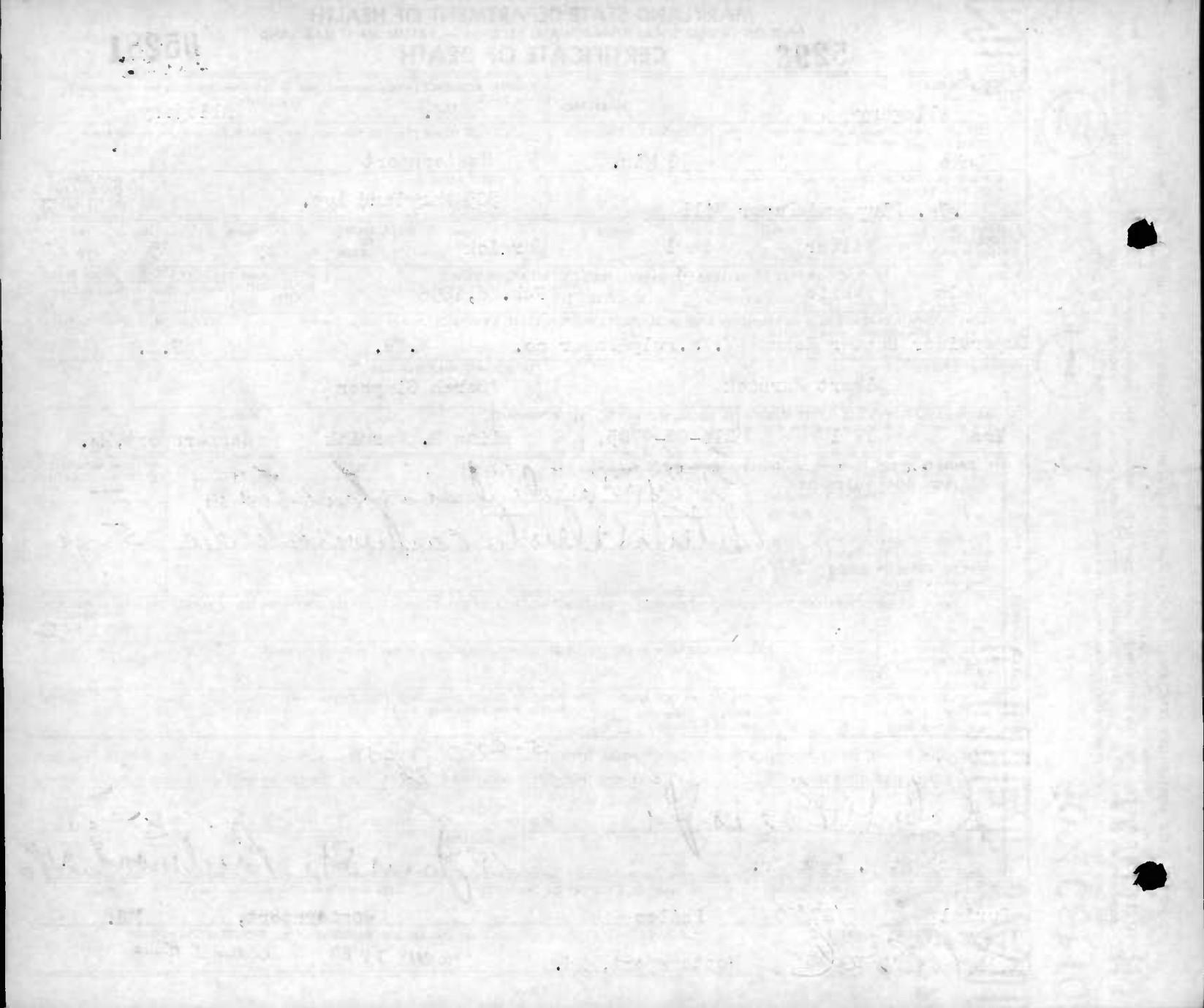
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5296

CERTIFICATE OF DEATH

05281

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke		c. LENGTH OF STAY IN 1b 30 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport		d. STREET ADDRESS 305 Maryland Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Va. Pulp and Paper Mill				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Walter	Middle Paul	Last Warnick	4. DATE OF DEATH	Month May	Day 25	Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 26, 1896	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Beater Room		10b. KIND OF BUSINESS OR INDUSTRY W. Va. Pulp & Paper co.		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Albert Warnick				14. MOTHER'S MAIDEN NAME Sarah Simpson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 1	17. INFORMANT Eliza M. Warnick	Address Westernport, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.1				<i>Myocardial infarction</i>			INTERVAL BETWEEN ONSET AND DEATH —	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)				<i>Anterior descending coronary artery dis.</i>			5 yr.	
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Manh. Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) 5-25-60	(County) 1960	(State) 1960		
21. I certify that (I) (this hospital) attended the deceased from 5-25-60 to 1960 , that (I) (we) last saw the deceased alive on 5-25-60 and that death occurred at 725 M. from the causes and on the date stated above.								
22a. SIGNATURE Robert W. Bess Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5-25-60			
22c. PHYSICIAN'S NAME (Type) Robert W. Bess Jr.		22d. ADDRESS 15 James St. Piedmont, W. Va.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/27/60	23c. NAME OF CEMETERY OR CREMATORIAL Philos	23d. LOCATION (City, town, or county) Westernport,	(State) Md.				
24. FUNERAL DIRECTOR'S SIGNATURE E. Boral				ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR MAY 31 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Krause	(State)	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
527 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05282
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Virginia		b. COUNTY Mineral				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley		d. STREET ADDRESS 117 Main St.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		85X-3										
3. NAME OF DECEASED (Type or print)	First Elijah	Middle Thomas	Last Wheeler	4. DATE OF DEATH	Month May	Day 26	Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 18, 1882	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 1	Hours 0	Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Foreman		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Tire Co.		11. BIRTHPLACE (State or foreign country) Jones Spring, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME William Wheeler				14. MOTHER'S MAIDEN NAME Sarah C. Everhart								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-07-0647		17. INFORMANT Mrs. Pauline Wilkinson		Address Ridgeley, W. Va.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS DUE TO (c) -----								INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) -----								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----										
20c. TIME OF INJURY Hour a. m. p. m. 19		Month, Day, Year -----	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----	(State) -----		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											DATE SIGNED	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> MAY 26, 1960											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/28/60	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland		(State) -----						
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Md.				ADDRESS -----		24a. REC'D BY REGISTRAR DATE MAY 31 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HUMAN SERVICES
STATE OF MARYLAND

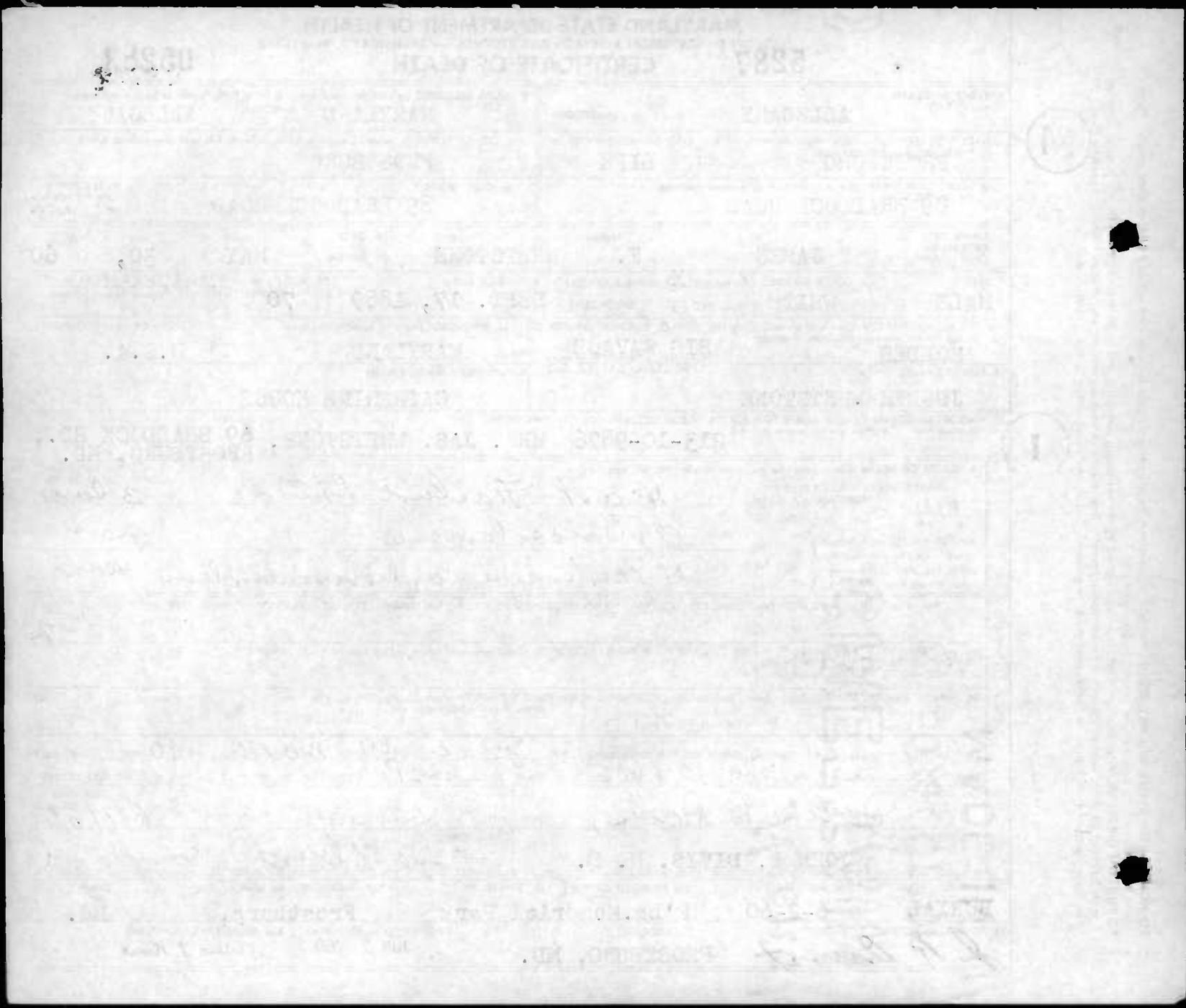
MARYLAND DEATH CERTIFICATE

First Name	MARY	Last Name	WILLIAMS
Middle Name	JOHN	Suffix	JR.
Date of Birth	1950-01-01	Age at Death	68
Sex	Female	Color	White
Address	12345 WOODSTOCK DR	City	BALTIMORE
State	MARYLAND	Zip	21207
Cause of Death			
Diseases or conditions contributing to death			
Other conditions contributing to death			
Medical Record Number			
Social Security Number			
Date of Report			
Signature			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										5287		05283		
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			d. STREET ADDRESS 22 89 BRADDOCK ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 89 BRADDOCK ROAD														
3. NAME OF DECEASED (Type or print)		First JAMES	Middle F.	Last WHETSTONE	4. DATE OF DEATH		Month MAY	Day 30,	Year 19 60					
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 17, 1889		9. AGE (In years lost on today) 70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOLDER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH WHETSTONE		14. MOTHER'S MAIDEN NAME CATHERINE HOUSE												
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-10-9876		17. INFORMANT MRS. JAS. WHETSTONE,		Address 89 BRADDOCK RD., FROSTBURG, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		INTERVAL BETWEEN ONSET AND DEATH 3 days				
								Heart Failure - Pt Side						
								Arteriosclerosis		years				
								Hypertensive Cardiovascular disease		years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)				
21. I certify that (I) (this hospital) attended the deceased from June 1949 to May 30, 1960 that (I) (we) last saw the deceased alive on May 30, 1960 and that death occurred at 2 P.M. from the causes and on the date stated above.														
22a. SIGNATURE John B. Davis,		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/1/60				
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M. D.		22d. ADDRESS Frostburg Maryland,												
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-2-60		23c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park		23d. LOCATION (City, town, or county) Frostburg,		(State) Md.						
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durst		ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE JUN 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5272 05284

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL, MEDICAL CENTER, OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD	
f. STREET ADDRESS 85X-3		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ELEANOR		First P.	Middle WILLIAMS
4. DATE OF DEATH MAY 6, 1960.		Month MAY	Day 6
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. WIDOWED <input type="checkbox"/>		9. DIVORCED <input type="checkbox"/>	10. DATE OF BIRTH MARCH 21,
11. AGE (In years last birthday) 77 yrs.		12. IF UNDER 1 YEAR Months	13. IF UNDER 24 HRS. Days
14. BIRTHPLACE (State or foreign country) WEST VIRGINIA		15. Months 7-10d	16. Days 7-10d
17. CITIZEN OF WHAT COUNTRY? U. S. A.		18. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis		INTERVAL BETWEEN ONSET AND DEATH 7-10d	
20. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE (b) DUE TO Perf. colon		INTERVAL BETWEEN ONSET AND DEATH 7-10d	
21. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE (c) DUE TO Hodgkin's Disease		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
23. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
25. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.		30. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
31. SIGNATURE Dr. A. J. MIRKIN		32. DATE SIGNED 22b. DATE SIGNED	
33. PHYSICIAN'S NAME (Type) Dr. A. J. MIRKIN		34. ADDRESS	
35. BURIAL, CREMATION, REMOVAL (Specify) Burial		36. DATE THEREOF May 9, 1960	
37. NAME OF CEMETERY OR CREMATORIAL OLIVET		38. LOCATION (City, town, or county) (State) MOOREFIELD, W. VA.	
39. FUNERAL DIRECTOR'S SIGNATURE KEITH SHAFFER - ROMNEY, W. VA.		40. REC'D BY REGISTRAR DATE MAY 24 '60	
		41. REGISTRAR'S SIGNATURE Charles L. Krause	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5273

05285

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG	
3. NAME OF DECEASED (Type or print) ANNIE		4. DATE OF DEATH MAY 17 1960	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) GARRETT, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Max Layman		14. MOTHER'S MAIDEN NAME LAURA C. WILHELM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular-renal disease		INTERVAL BETWEEN ONSET AND DEATH 5 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 442X DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-13 1960 to 5-17 1960 that (I) (we) last saw the deceased alive on 5-17 1960 and that death occurred 135P M. from the causes and on the date stated above.		22b. DATE SIGNED 5-18-60	
22a. SIGNATURE Ralph L. Ballin		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) RALPH BALLIN		22d. ADDRESS 62 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20 1960	
23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frostburg Mem. Pk.		23d. LOCATION (City, town, or county) Frostburg	
24. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		25a. REC'D BY REGISTRAR DATE MAY 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05286

5274

PLACE OF DEATH a. COUNTY ALLEGANY			MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND			b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN lb 7 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 WESTERNPORT						
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.			e. STREET ADDRESS 1 241 W. MAIN ST.			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EFFIE			First Middle			4. DATE OF DEATH WILT			Month Day Year MAY 19 160			
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JULY 20			9. AGE (In years last birthday) 71 yrs.			IF UNDER 1 YEAR Months Doy		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) GARRETT CO., MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME THOMAS WILT			14. MOTHER'S MAIDEN NAME ELIZABETH PLATTER			Address MEMORIAL HOSPITAL CUMBERLAND, MD.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			INTERVAL BETWEEN ONSET AND DEATH 10 days			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33 IX			Cerebro-vascular accident - hemorrhage									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertension									??			
DUE TO (b) Hypertension												
(c) Uremia												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 5/12 1960 to _____ 5/19/60, 19_____, that (I) (we) last saw the deceased alive on _____ 5/19 1960, and that death occurred at _____ 1:15 PM, from the causes and on the date stated above.												
22a. SIGNATURE <i>Samuel Jacobson</i>			M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE 5/20/60		SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL JACOBSON			22d. ADDRESS 50 PERSHING ST., CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/22/60			23c. NAME OF CEMETERY OR CREMATORIAL Philos			23d. LOCATION (City, town, or county) Westernport		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>El. Baval</i>			ADDRESS Westernport, Md.			25a. REC'D BY REGISTRAR DATE MAY 25 '60			25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>			

DO NOT ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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